Michael R Wanlass DDS

Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of **estimated** patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) Cash, Check, Visa/MasterCard, and American Express.
2) Flexible payment plans of up to 6 months upon approval with Wells Fargo or Care Credit. Approval must be received prior to treatment date.

As a courtesy to you, we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. **Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. _______** initial

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. ______ initial

In certain circumstances, insurance companies may send a check for services provided by Wanlass Dental directly to the patient. In such cases, the patient agrees to endorse and send such a check to Wanlass Dental. If the patient deposits such a check into a personal account, the patient agrees to send a personal check for the equivalent amount to Wanlass Dental within 10 days of having deposited the check from the insurance carrier. ______ initial

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 3% per month interest. I am responsible for **all collection costs incurred by the dental office** and on a returned check, a fee of $30.00. ______ initial

To help us better serve you, we request that you provide 24 hour prior notice of any necessary appointment changes. If this notice is not received, a minimum $25 fee per hour appointment or a percentage of the scheduled services will be applied to your account. ______ initial

Release of Medical Information:

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my family, to give copies. A photographic copy of this authorization shall be as valid as the original.

Signature of Patient / Legal Guardian ________________________________ Date ________________________

Printed name Patient/Legal Guardian ________________________________

Relationship to Insured: ________________________