

# Wainwright Dental & Associates

12055 Spring Cypress Road  
Tomball, TX 77377

## Financial Policy

We are pleased to welcome you to our practice and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services we provide to you. To assist us in achieving these goals, we ask that you review our financial policy before signing.

At this time, we are a provider for a few Dental PPO plans. We will file your dental claims for you at no charge to the best of our ability, however all treatment charges are the responsibility of the patient regardless of insurance coverage. Payment for your treatment is due at the time services are rendered; this would include your deductible and your percentage cost of treatment. We do accept all major credit cards for payment and third party financing is available. If we cannot settle a claim within 60 days from your treatment date, you will be responsible for paying the balance. Please remember that your insurance is a contract between you and your insurance company and/or employer, and our dental practice is not a party of the contract. We recommend that any questions regarding the amount of insurance coverage for treatment is discussed directly with your insurance company or employer; we will do all we can to assure you of maximum benefits.

There will be a \$25.00 NSF fee on any returned check plus the fee of the check; this must be cleared up immediately and paid with cash or money order. Also, please remember that we require 24 hour notice for rescheduling appointments. A \$75 fee will be assessed for cancellations with less than 24 hour notice and missed appointments. We understand that emergencies arise, we just ask that you let us know as soon as possible so that we may give your appointment slot to someone else. Once an appointment has been made, this time has been specifically reserved for you, and the missed appointment fee is not a covered expense by your insurance company. Please sign below stating that you understand our Financial Office Policy and agree to be bound by its terms. Also, signing this form lets the insurance company know that you have authorized insurance payments to be made to Dr. Wainwright for all treatment performed in our office commonly referred to as assignment of benefits. Should you have any questions please don't hesitate to ask.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have read and understand the HIPPA authorization. I authorize the disclosure of my health information as described in the form.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_