

# Dentistry at Windermere Financial Policy

We Thank You For Choosing Dentistry at Windermere for your Dental Needs.

We appreciate the value of your time and strive for on time appointments. Our goal is to give each patient the personal & individual attention they deserve – **for each and every appointment**. We work by scheduled appointments and ask that you make every possible effort to be on time for the appointment we have reserved especially for you. **Please give us 48hrs. notice if you find it necessary to cancel or reschedule your reservation.**

**Or a broken appointment fee of \$50.00 may be assessed.**

**First Offense:** A verbal reminder of our office policies

**Second Offense:** Written notice with a \$50.00 charge posted & billed to your account.

**Third Offense:** Showing a lack of commitment for your dental health, may lead to being asked to seek another dentist for your dental treatment.

## Financial Obligations

**Services are due & payable at the time service is rendered in our office.** As a courtesy, if you have insurance, we will accept the assignment of benefits and ask that you pay only the estimated portion of the day of service (**which is estimated by our office from the information we have collected on the phone from your ins co – this is not an authorized pre-treatment estimate from your insurance company**). You will be billed & fully responsible for any remaining balance after the insurance has paid. Should the insurance benefit check be sent to you, you will need to pay us immediately. (you are responsible for monitoring your dental benefits).

**Should your account become 90 days PAST DUE**, (regardless of insurance) the account may be turned over for collection and you will be responsible for the balance, along with any fees incurred, such as collection fees, court cost and attorney fees.

**I understand and Agree:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Patient Signature)

**By signing, I authorize Dentistry at Windermere to submit my claims electronically and to assign benefits to be paid directly to them. I understand that any claim or unpaid portion of a claim(s) is solely my responsibility and I agree to pay the dental office in full.**

## Clinical Consent:

\_\_\_ I agree to update myself and my dependents medical & personal history as required.

\_\_\_ I hereby authorize Dentistry at Windermere to perform any necessary and mutually agreed upon x-rays, study models, photographs (for diagnostic & identification purposes), or any other diagnostic aids deemed appropriate by the dentist for proper diagnosis.

\_\_\_ Upon such diagnosis, I authorize Dentistry at Windermere to perform any mutually agreed upon treatment, and to employ such assistance as required to provide proper care; including, aesthetics, sedatives, & other medications as necessary. I fully understand the use of anesthetic agents embodies certain risk. I understand that every precaution will be taken and that I may ask for a complete recital of any possible complications.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**(parent/guardian should sign for minor)** \_\_\_\_\_ **Date:** \_\_\_\_\_