DENTAL CORNER
2046 N. OLIVER AVE
WICHITA, KS 67208-2503
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(316)681-2425
xrays@dentalcorner.kscoxmail.com

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy. We require that you read and sign this prior to any treatment.

Full payment is due at the time of service. Treatment estimates are only estimates. We are committed to your estimate being as accurate as possible; however, sometimes it is necessary for the estimate to change during the course of treatment. Should your account balance exceed 30 days, an annual percentage rate of 18% will be applied.

In the event that you apply for our In-House Financing, and are approved, any late payments will be assessed a $25.00 late fee for payments not received by their due date.

I understand that treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my responsibility.

We accept cash, checks, debit card, Visa, MasterCard, Discover and American Express.

Regarding Insurance

We will accept assignment of insurance benefits and file your dental claim for you. Your insurance policy is a contact between you and your insurance company. We are not part of that contract. We will do everything possible to assist you in getting the proper reimbursement. Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. The balance is your respondibility whether your insurance pays or not. Any patient receiving treatment is responsible for full payment. Should your account balance exceed 30 days, an annual percentage rate of 18% will be applied. Any patient receiving treatment during hours that insurance can't be verified is responsible for full payment.

Failed Appointments

There will be a $35.00 charge for failed appointments or if you cancel with less than a 24 hour notice. If you need to reschedule an appointment, we require 24 hours notice. If you fail three appointments, we reserve the right to dismiss you as a patient. As of 1/1/2012 there will be a $35.00 deposit to schedule an appointment on Saturdays.

INSURANCE AUTHORIZATION

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I have received and understand this practice's Notice of Privacy written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practices legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.
I have read the financial policy and insurance authorization above. I understand and have recieved a copy of these policies.

Signature: ______________________________

Date: [ ]

Response Date: [ ]