The Wellness Center

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Financial and Insurance Policy

Welcome to The Wellness Center, it is a pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations. The following is our office payment policy:

For Our Patients WITH Dental Insurance:

As a courtesy, we will file your insurance claims and accept assignment of dental insurance benefits provided you agree to the following:

- While the filing of insurance claims is a courtesy, we must emphasize that as dental care providers, our relationship is with the patient, not the insurance company. If we do not receive payment from your insurance company within 60 days, payment becomes your responsibility.

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.

- Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **YOUR** responsibility. We will do our best in estimating your patient portion, however, receiving our services indicates your acceptance of responsibility to pay any amount your insurance doesn't cover regardless of our estimate or their reason for non-payment.

- Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and patient portions are due at the time of treatment.

- We accept **cash, check, debit or credit card** (Visa, MasterCard, Am Ex & Discover)

- We have made arrangements with Care Credit and Chase Health Advance to provide extended payment plans with no interest. Applications are available from our front office staff and provide instant approval.

For Our Patients WITHOUT Insurance Coverage:

- We provide a written estimate of fees and payment is expected at time of service, in advance if taking advantage of the courtesy adjustment, or in accordance to a payment arrangement.

Minor Patients:

- The parent or guardian accompanying the minor is responsible for payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without exception.

Other Fees:

- There is a $35.00 fee if your check is returned to our office unpaid by your financial institution.
- Outstanding balances over 60 days are subject to an interest charge of 18% APR. Collection costs and reasonable attorney fees incurred in attempting to collect past due balances are the responsibility of the patient. In an attempt to avoid such action, we encourage you to communicate any problems you may be having in paying your balance immediately so we may assist you in the management of your account.

Broken or Missed Appointments:

- Your appointment time is reserved just for you. We require 48 hours notice if you are unable to keep your appointment. Less than 48 hours notice is considered a broken appointment. Broken appointments prevent others from receiving the dental care they deserve. Please be considerate and inform us in advance if you need to change your appointment. A fee of $50.00 will be charged for broken appointments.
- We are making every effort to stay on schedule so please arrive promptly for your appointments. We reserve the right to reschedule late patients.

Consent & Authorization:

- I authorize dental treatment and agree to pay all related fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office.

We hope that by presenting our policies to you, we will avoid any misunderstandings, and therefore, have more time to dedicate to your dental care. If you have any questions regarding the above information, please do not hesitate to ask – we are here to help!

I certify that I have read, understood, and received a copy of the above Financial and Insurance Policy. I hereby authorize Dr. Terecita L. Dean, to submit and to sign insurance claims on my behalf. I hereby authorize the release of any information, pertinent to my case, to my insurance company or their agents. I understand that this authorization is a direct assignment of my rights and benefits under my policy and that payment will be made directly to "Dr. Terecita L. Dean".

I understand my financial responsibility for dental treatment.

Patient's Signature or Legal Guardian of Minor Date