Patient Name (print): _____ Date of Birth: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Wheaton Cosmetic Dentistry as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this for to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- Patient understands that our office will try to ESTIMATE insurance benefits and patient out of pocket expenses as closely to accurate as possible. However, any insurance, whether Dental or Medical can never guarantee benefits and any information obtained from your insurance company is only a quote of benefits. Ultimately, any procedures, charges or assessed fees not covered by your dental/medical policy are your responsibility.
- Co-pays are due at the time of service (unless other written financial arrangements have been made and approved prior by office personnel).
- Any remaining balances due by patient will have a statement issued and are due 30 days from receipt of billing.

Our office reserves an appointment specifically for you on a date and time which you have requested and approved. Our office extends multiple options for patient appointment correspondence including, but not limited to:

Phone Call Reminders, Text Message Reminders, Email Reminders, Voicemail Reminders

- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks ($35 Insufficient Funds Fee)
  - Charge for missed appointments without 24 hours' notice (these penalties range from $35-$75 depending on the appointment time specifically reserved for you, by your provider, per your request.)
- Patient understands that it is his/her responsibility to give minimum 24 hour notice to cancel a reserved appointment time they have made to avoid any penalties and that NOT confirming his/her reserved appointment does NOT qualify as giving notice that he/she does not intend on keeping that appointment.

COLLECTION POLICY: An account is considered delinquent when patient has not paid within 30-45 days after Wheaton Cosmetic Dentistry's billing or if payment in full has not be received within 30 days of the final insurance payment. Delinquent accounts can be assessed penalties and interest and may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees and other costs incurred and/or expended as a result of such proceeding.

By my signature below, I hereby authorize assignment of financial benefits directly to Wheaton Cosmetic Dentistry and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

(If patient is a minor, please print the name of the parent/legal guardian): _____

_____ _____

Signature of patient or guardian Date