Jay B. Wardius, D.M.D.

Cosmetic and Implant Dentistry

Your Invitation to a Beautiful Smile

Patricia A. Wardius, D.M.D.

PATIENT FINANCIAL POLICY

PATIENTS WITH INSURANCE COVERAGE

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payment of your account.

We will be happy to request a pre-treatment estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-treatment estimates.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Even if you have double coverage (for example, if you and your spouse both have dental insurance), there may still be a portion that will be your responsibility.

If you are having treatment over a period of time, we appreciate payment during the course of treatment. Patients without insurance coverage are requested to pay at time of service. We accept personal checks, Visa, MasterCard, and offer financing through Care Credit. Care Credit allows you to pay over time with no interest, low monthly payment plans available, and no annual fees or pre-payment penalties. Ask the front desk if you would like to apply.

ADDITIONAL TERMS

Checks returned by your bank are subject to a $25.00 processing charge. If your account is referred for collections, you will be responsible for collection costs in the amount of 35% of the outstanding balance, together with court costs and reasonable attorney's fees.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee ($75.00) for any appointments not canceled at least 24 hours prior to your scheduled appointment. Please call us as early as possible if you know you will need to reschedule your appointment. Three missed appointments will result in discharge from the practice.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best possible care.

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF DR. JAY B. WARDIUS AND DR. PATRICIA A. WARDIUS.

X____ ______________________

Signature of Patient or Guardian Today's Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named of the benefits otherwise payable to me.

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