Joseph A Wescott, DDS
Island Dental
Financial Policy

Thank you for choosing us as your dental care provider. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. All patients must complete our patient information documents in advance of treatment by the dentist.

REGARDING INSURANCE

We accept assignment of insurance benefits at the same time of service. **We cannot bill your insurance unless you provide all of your insurance information (ie: insurance card and correct billing address).** *Your insurance policy is a contract between you and your insurance company. We are not party to that contract. It is your responsibility to know your particular coverage pertaining to deductibles, co-pays, and if we are listed as providers for your particular dental health plan*. **If your insurance company has not paid your account in full within 120 days, you will be responsible for the remaining balance unless prior arrangements have been agreed to in writing with our Office Manager.** Please be aware some and perhaps all services provided may be non-covered services and not covered under your dental insurance policy.

Please understand that we file primary insurance claims as a courtesy for you, our patient. *If you have a supplemental or secondary insurance plan, we will be happy to provide a receipt for the care you received thus you are solely responsible for billing your secondary insurance provider.*

All patients are responsible for payment (including co-payments and deductibles) at the time of service. The adult accompanying a minor is responsible for payment in full. Minor patients not accompanied by an adult may be denied service (except in cases of emergencies) unless prior written approval has been given for those services.

I further agree to pay all finance charges, collection cost, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

Thank you for your understanding. Please let us know if you have any questions or concerns.

I HAVE READ THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY ISLAND DENTAL. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO ISLAND DENTAL. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Signature:_____Date:_____

Name (Please print):_____