Wakarusa Family Dental Office & Financial Policy

We would like to thank you for choosing Wakarusa Family Dental as your dental provider. As one of our patients, we would like to keep you informed of our current Office and Financial Policies. We require you to read and sign this document prior to any treatment.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office **as soon as possible to cancel or reschedule**. The sooner you contact us, the more time we have to provide another patient with the available time slot.

Broken Appointments "No Show, No Call": Your appointment time has been reserved especially for you and we strongly encourage all of our patients to keep their appointments. We reserve time in our schedule to accommodate our patients. When we have someone not show or call to cancel their appointment last minute, it is time lost that we could have provided dental care to another patient in need. **A fee of $25 will be charged to any account that has *two consecutive* "no show/no call" missed appointments per family. *Each additional consecutive* *"no show/no call" missed appointment will be charged an additional $25.***

No Insurance: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Billing Department.
We accept Care Credit for your dental financial needs. Care Credit offers no interest or low interest monthly payments. We have applications available for your convenience.

Insurance: Please bring your dental insurance card(s) with you at the time of your appointment. It is **YOUR** responsibility to provide us with the correct, current insurance information for you/your family. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance company.

Past Due Accounts: A service charge of 1.5% per month on any unpaid balance will be charged on all accounts exceeding 60 days, monthly, until balance is paid in full.

Returned Checks: A $30.00 charge will be added to your account for any check returned by your bank for any reason.

Patient Financial Responsibility:
I acknowledge full financial responsibility for services rendered by Wakarusa Family Dental. I understand I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand my account will be charged a 1.5% per month finance charge on any unpaid balance exceeding 60 days. I understand my account will be charged a $25 fee if I, or anyone in my family have *two consecutive* "no show/no call", missed appointments. In the event I fail to pay the balance due for services (or goods received) and it is necessary to employ outside collection efforts, I understand that I am responsible for the costs of collection, including, but not limited to, court costs and attorney fees which shall not be in excess of 15% of the unpaid balance at the time of default.

Patient's Name_____

Responsible Party's Signature:_____ Date:_____

Please feel free to ask us for a copy of this signed document