

Waverley Dental Care

PAYMENT POLICY

Thank you for choosing Waverley Dental Care as your dental health care provider. We are committed to the success of your dental care and want to provide you with the best service possible. To help reduce our administrative costs and keep our fees to you as low as possible, *Waverley Dental Care requires payments to be made at the time you receive treatment unless other financial arrangements have been made.* We accept cash, check, and Visa/MasterCard.

Payment Plans

Waverley Dental Care is happy to offer a payment plan for treatment fees of \$300 and up. Our finance plan will allow you to make payments over a period of months, and up to five years with no interest or low fixed interest terms. This plan is subject to approval (based on credit score). If you are interested in financing, arrangements must be made *before* treatment is rendered. Please see front desk for details.

For patients with dental insurance

Due to constant changes in insurance plans, it is not possible for us to interpret each individual policy. It is your responsibility to know your dental coverage and eligibility status. Having dental insurance is not a guarantee of payment. Most treatments carry a co-payment/deductible and many services are not covered at all. Based on the dental plan details available to us, we can *estimate* the amount of your co-payments to the best of our abilities, however, until a claim is formally processed, there is no guarantee. If your insurance company fails to pay your dental claim within 60 days you will be held responsible for the full amount.

Acceptance Agreement

- I have read and understand the above financial policy
- I understand that I am responsible for payment on services that are not covered by my insurance company as well as co-pays and deductibles after insurance has paid its portion of covered services.
- I understand that the parent or guardian bringing a child for dental treatment is responsible for all fees incurred at that visit
- I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient's printed name: _____

Patient's Signature: _____

Guardian's Signature (if patient is younger than 18): _____

Today's Date: _____