

# **Robert I. Wier DDS LTD.**

## **Office Financial Policy**

I understand that I am responsible for all fee's related to my care. I understand that full payment for all dental treatment is to be paid when it has been performed.

I understand that any and all account balances 60 days or more will incur a \$25.00 monthly billing fee.

I understand that if my account is not paid in a timely fashion, my account will be turned over to an attorney, and in addition to paying my balance, I agree to pay all attorney fees and collection costs.

## **Patients with Dental Insurance**

I understand that my insurance policy is a contract between myself and my insurance company.

I am responsible for the above financial policy information.

I understand that I am ultimately responsible for any and all balance, even if an insurance company agreed to pay a balance and at a later date did not pay.

I will pay my estimated portion (that portion not covered by my insurance company) at the time of service. The dental staff will process and submit my paperwork to my insurance and wait for payment from them. If after 60 days my insurance has not paid the balance, the balance now becomes my responsibility and payment is now due in full. When insurance payment is received by the office, it will be mailed to me.

## **Broken Appointments**

We reserve the right to charge a broken appointment fee for any appointment not kept by the patient.

Patients will be charged \$50.00 per 1/2 hour appointment time that the office had set aside for that day. This charge will also be applied if the patient cancels their appointment less than 24 hours prior to their scheduled time.

After two broken appointments, we retain the right to discontinue treating you for elective treatment. If you wish, we can provide you with names of other dental offices in the area to continue your treatment. We will mail a copy of your X-rays to the dentist of your choice. X-ray copy fee is currently \$30.00.

Signature \_\_\_\_\_

Date \_\_\_\_\_