Wright Dental Financial Policy

At Wright Dental, we strive to provide the highest level of dental care. To maximize time with each and every client, the following policies have been created.

Please take the time to understand these policies and how they relate to you.

Patients are expected to pay for the services we provide at the time they are rendered. Care Credit is our financial in-house credit option. Please inquire if you would like more information regarding this.

Payment at the time of Service: Payment is due at the time of service. For patients who have insurance we will continue to submit to your insurance company. **The insurance company will reimburse you directly for your benefit.** All of our doctors will diagnose treatment based on optimizing your dental health not your insurance coverage.

Cancellation Policy: We do enjoy allowing you to schedule your appointment to fit your schedule but please understand we set this time aside exclusively with our hygienist and doctors. However, our cost of providing care increases greatly when patients fail to keep scheduled appointments. We require 48-hour notice for cancellation of any appointment. Failure to appear for a scheduled appointment or cancellations that are made within 24 hours are subject to a cancellation fee.

I, _____ have read and understand the above financial policies. I agree to the cancellation policy, and I agree to pay my financial responsibility promptly as indicated by these policies. Further, by initialing below, I agree to and understand the following patient responsibilities:

_____ I understand that payment is due at the time my dental services are rendered.

_____ I understand that it is ultimately my responsibility to know and understand my insurance policy including but not limited to deductibles, co-payments/co-insurance amounts, authorization requirements, wait periods, covered and non-covered services. I understand that Wright Dental may contact my insurance company directly to verify my insurance benefits, but that this is only an estimate and not a guarantee of coverage.

_____ I understand the cancellation policy.

Acknowledgement: I have read and understand the above financial policy. For mutual convenience of you and the practice, it is understood that this executed copy of our Financial Policy shall also cover your dependent children who are patients of the practice.

Patient or Responsible Party Signature _____Date_____