Dental Health Services

1901 Ridgewood Rd | Wyomissing PA, 19610 | 6103733720

Written Financial Policy

Thank you for choosing Dental Health Services. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

INSURANCE PLANS

In order for us to file your insurance claim we must have a copy of your current insurance card. If you do not have your insurance card at the time of service, full payment is due at the time of services

You are responsible for all co-pays and deductibles at the time service is rendered.

Filing insurance claims is a service we provide free of charge as a courtesy but in no way relieves you from the responsibility of your bill.

It is your responsibility to know your insurance policy rules and benefits.

> Note: We file claims for many different insurance companies, and it is virtually impossible for us to know your individual insurance policies. We will give your our best estimate regarding your treatment plan, but this does not **guarantee** that your insurance will cover the charges. Specific questions should be directed to your insurance carrier.

It is your responsibility to let us know if your insurance has changed prior to your appointment. Do not assume that your insurance has not changed.

MISSED APPOINTMENTS

We reserve Dr. time especially for you. While we do understand that emergencies do occur, we ask that you give us **24 hours** notice if you are unable to keep you appointment. Other patients in need of our time and care can then be called.

We charge $25 for appointments cancelled or missed without 24 hours notice.

Dental Health Services charges $30 for returned checks.

Dental Health Services reserves the right to charge the applicable amount allowed by law for duplication of records or x-rays. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of the financial policy shall be considered as effective and valid as the original. Regardless of what insurance I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Dental Health Services. I agree to all collection fees and court costs if necessary to collect on my account.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.