Office Policy

Thank you for choosing Wright Smiles. We are committed to providing your child with the best dental care. Your clear understanding of our Office Policy is important to our relationship.

Appointments:

• All necessary paperwork must be completed prior to being seen. These include patient charts, health history, consent forms and treatment plans.
• Payment is due in full the day of the appointment. If our estimate is more than what your insurance company originally estimated a refund will promptly be given. If the estimate is less, you will receive a billing statement by mail with your additional responsibility.
• A parent or legal guardian must accompany the patient to their first visit.
• We accept cash, check, Visa, Mastercard, Discover, and Care Credit.
• A 24-hour notice is required to change/cancel appointments to avoid a potential charge on your account.

****If you need to change your appointment date and/or time to avoid a $45.00 charge per hygiene appointment and $75.00 for treatment appointment that is scheduled. You may call and leave a message at our office 24 hours a day. **** **Initial_____**

Insurance:
• As the responsible party, it is your responsibility to provide complete and accurate information regarding your policy. This includes the personal information of the policy holder i.e., Name, date of birth, employer, social security number, member ID, network status, and claims address. If you are unable to provide these details at the time of the appointment, you can choose to pay out-of-pocket for the appointment or to reschedule for a later date.
• Your insurance policy is a contract between you and your insurance company. We are not a party to that Contract. If your insurance company has not paid within 60 days, the claim will be closed, and the balance will be transferred to you. Once you contact your insurance company regarding the claim, we will resubmit accordingly.
• We will also expect you to know your maximum's, deductibles, and policy limitations prior to treatment. We cannot accept the responsibility of knowing all the details about your personal policy. Any Amount not paid by your insurance is your responsibility regardless of any estimation of benefits made by our office. **Initial_____**

Accounts:
• Past due balances are subject to additional collection fees. Should you allow your account to be turned over to collections you will be responsible for all fees and expenses and will only be seen as a "self-pay" patient for future appointments the same guidelines apply if bankruptcy is filed.
• Payment is due in full the day of the appointment for all "self-pay" accounts.
• Our office does not get involved with 3rd party billing. The legal guardian that brings the child in for a visit is responsible for payment in full that day. **Initial_____**

Thank you for understanding our Office Policy. Please let us know if you have any questions. "I have read and understand that regardless of my insurance status, I am ultimately responsible for the balance on my account."

Patient Name:_____

Parent/Guardian Signature:_____ Date:_____