Webster-Kirkwood Family Dental

We are committed to providing you with the best possible care and are happy to discuss our professional fees with you at any time. Your clear understanding of our financial agreement is important to maintaining a positive professional relationship.

1. **Appointments-** To ensure the best service for all our clients, we kindly request 24 hours' advance notice for any appointment cancellations. Please note that a $30 fee may be charged for missed appointments or same day cancellations. If a patient repeatedly fails to show up for scheduled appointments, we reserve the right to dismiss the patient from our practice.
2. **Late appointment arrival-** To ensure you receive the best quality care during your appointment, we ask that you arrive before your scheduled time. Please note that patients who are 15 minutes late will not be seen.
3. **Co-Payments and Estimated Out of Pocket Expenses-** Estimated out-of-pocket expenses, such as deductibles and co-insurance, are due at the time of your visit. Please note that there are no exceptions to this policy. We will submit a claim to your insurance plan on your behalf.
4. **Self-Pay Payments-** Payment for all services are due when services are rendered.
5. **Divorced/ Separated Parents of Minor Patients-** The parent who provides consent for the treatment of a minor child is responsible for payment of all services rendered. Please note that WKFD will not be involved in disputes related to separation or divorce.
6. **Insufficient Fund Checks-** A fee of $25 will be applied for checks returned due to insufficient funds.
7. **Balance on Account-** We expect to be paid in timely manner. Account with balances 31+ days after insurance pay; could incur a 2% monthly fee.
8. **Collection Fee-** Accounts with a balance overdue by 90 days or more will be referred to a collection agency. At this point, no further contact will be made by our office, and the patient will be discharged from our practice. The guarantor will be responsible for all costs associated with collections, including reasonable interest, attorney's fees, and collection agency fees, which will not exceed 33 1/3 % of the outstanding balance.
9. **Non-Covered/Denied Services-** These services will be the responsibility of the patient and be billed accordingly.
10. **Office Xray Policy-** At WKFD our policy is to perform bitewing X-rays once calendar year and a full mouth series every 5 years; to ensure we have the necessary diagnostic information to provide the best care possible. As licensed providers, we are committed to ethical principles that prioritize your health and well-being. While you have the right to refuse X-rays, please understand that we cannot proceed with cleanings or treatment without them, as adhering to the standard of care requires the use of appropriate diagnostic tools.

I have read and fully understand each item of the practice's financial agreement and agree to be bound be its terms. I also understand and agree that these terms may be periodically amended by the practice.

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Print Name Patient/Guardian Signature Date