B. WELL DENTISTRY
Financial Policy

Effective January 1, 2016

We appreciate the opportunity to serve you. We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

ON DAY OF SERVICES: All fees for non-insured patients and patient's with dental coverage (the estimated patient co-pay and deductible for the treatment rendered) must be **paid in full on the day of service.**

SEPARATED/DIVORCED PARENT OF MINORS who are each responsible for one half of the cost of a child's/children's dental care, **the parent who brings the child in is responsible for paying the co-payment or full fee.** It may be necessary to have a credit/debit number from the non-custodial parent on file.

FORMS OF PAYMENT ACCEPTED: We accept Visa, MasterCard, Checks, and Cash for Payment of the amount due. Payment arrangements are available through Care Credit, On Approved Credit.* You can extend your payments 3, 6, or 9 months without interest. Ask for details or Apply at Carecredit.com.

CANCELLED APPOINTMENTS: We ask our patients to give our office 48 hours notice to reschedule their appointments.
*We understand that schedules can change unexpectedly and 48 hours notice is not always possible, however, we still do expect a phone call if you are unable to make your scheduled appointment.
*A no call no show will result in a $50 charge to your account for every hour you were scheduled.

TREATMENT PLANS: You understand that if the Doctor has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment.

PAYMENTS: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by fifteen (15) days after the statement date.

FINANCE CHARGE: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.0%) per month or an ANNUAL PERCENTAGE RATE twelve (12%) percent. The finance charge on your account is computed by applying the periodic rte (1.0%) to the "overdue balance of your account". The "overdue balance" of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time.

INSURANCE: Insurance is a contract between you and your insurance company. We will bill your insurance company as a COURTESY to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. ***If your insurance company has not paid your claim within sixty (60) days after the date of service, the full amount is due and payable by you. We will promptly refund to your any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.***

BY EXECUTING THIS AGREEMENT, YOU CONSENT TO TREATMENT BY DR. SPENCER BRAMWELL AND HIS STAFF AND YOU ALSO TO PAY FOR ALL SERVICES THAT ARE RECEIVED. ONCE YOU HAVE
SIGNED THIS AGREEMENT, YOU ALSO AGREE TO ALL THE TERMS AND CONDITIONS CONTAINED HERIN AND THE AGREEMENT WILL BE IN FULL FORCE AND EFFECT."

Patient Printed Name: ____________________ Date: ____________

Patient Signature: ____________________ Date: ____________

If Minor Patient (Under 18 years old)
Guardian Signature: ____________________ Date: ____________