FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE
BRUCE C. WETMORE, D.D.S.
Diplomate of American Board of Oral & Maxillofacial Surgery
Practice limited to Oral & Maxillofacial Surgery

Patient Name:_____

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. Although we are not a contracted provider for medical plans, some medical policies do cover certain procedures. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We do our best to estimate what your responsibility will be, but insurances do not guarantee amounts or eligibility over the phone. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover and/or will "down code" to an alternate procedure/code increasing your liability. We will be happy to process your insurance claim. However, any estimated co-pay or percentage for which you are responsible for is due at the time of service. Our practice is committed to providing the best to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Missed appointments (no shows) affect our ability to provide timely attention to our patients. When a patient does not show up for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our office at least 48 business hours in advance, failure to do so will be considered a missed appointment or no show and subject to a charge of $100.00 for surgical appointments and $50.00 for all others.

I have read the above information and I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. When professional services are rendered to a minor, both parents and/or legal guardians are considered the responsible parties. I agree to pay a minimum of $5.00 or interest at the rate of 1.75% per month (whichever is greater) on any balance not paid within 90 days of the date of service. In, addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 (whichever is greater) to offset part of the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee. Please note that we do require the social security number(s) of the responsible party/parties.

TCPA acknowledgement: I authorize this office, its agents and assignees to contact me by telephone, text, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

We accept cash, debit cards, Master Card, Visa, Discover and Care Credit.

<u>*WE DO NOT ACCEPT CHECKS*</u>

_____Date_____
Signature of Patient or Responsible Party