Winston-Salem
Dental Care

Kenneth M. Sadler, DDS and Associates, PA
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Patient Financial Responsibility

Signature: *I certify that I,_____ , (or my dependent) have dental insurance coverage and assign directly to Kenneth M. Sadler, DDS & Associates, PA, Winston-Salem Dental Care (WSDC) all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize WSDC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If I do not have dental insurance, I understand that I am (or my responsible party is) responsible for 100% of the fees on or before the day of treatment unless prior arrangements have been established.*

Payments: *Pre-payment is required for all prescribed/accepted dental treatment. Collecting in advance or on the day of appointment before being seen by the provider allows our office to reserve the time with your provider. When you prepay for treatment you are agreeing to take care of your dental needs. Money paid as pretreatment in advance of service(s) will not be refunded but will be handled as a credit to your account. If you establish a payment plan through WSDC or one of its finance companies you are responsible for all charges incurred. A $25.00 fee will be charged for any returned check.*

Billing Policy: *A photo ID and insurance card are required of all patients. WSDC will submit a bill to your insurance company for services rendered. Once payment is received from the insurance company you will receive a Patient Statement detailing any balance(s) due to WSDC. Payment is expected within ten (10) days from receipt of the Patient Statement. Any unpaid balance over 90 days may be turned over to a collection agency and/or attorney and the account holder will be responsible for the balance and collection and attorney fees.*

Unpaid Insurance Benefits: *WSDC cannot render services on the assumption that my charges will be paid by the insurance company. I understand that any dental services furnished by WSDC, whether I have insurance or not, are directly charged to the policy holder or patient and that I am personally responsible for payment for all services.*

Treatment Estimates: *WSDC routinely provides our patients with a written estimate of the cost of prescribed treatment. Since your insurance determines the benefits payable for services, WSDC cannot be held responsible for 100% of the accuracy on any estimate for treatment. Treatment estimates are valid during the calendar year in which they are calculated.*

Alternate Benefits: *I understand that most insurance companies downgrade coverage on non-metal restorations and I agree to the adjusted fees for alternative materials.*

Condition of Treatment: *As a condition of treatment, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) on the part of each patient is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are rendered.*

Missed or Broken Appointments: *WSDC understands that even the best of plans can fall victim to cancellation. We require that cancellation of a scheduled appointment be done within 48 hours. Cancellations not received within this time frame or not showing up for an appointment without calling to cancel may result in a fee of $25.00 being charged to you, future withholding of assignment of a patient appointment time and/or require you be worked into an existing schedule without a specificly assigned time.*

WSDC reserves the right to update this Office Policy at any time without notification. My signature verifies I have read, understand and accept the policies described above.

Patient Name (Print) _____ **Signature: _____**

WSDC Representative Signature: _____ **Date:_____**