William H. Walls, D.D.S., P.C.

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STATEMENT OF FINANCIAL POLICY

Welcome to William H. Walls, D.D.S., P.C. and thank you for choosing us as your dental health care provider. We are committed to providing you and your family with the best treatment possible. The following is a statement of our financial policy which we require you to read and sign prior to any dental treatment. If you have any questions, please do not hesitate to ask.

Method of Payment - We accept the following methods of payment: Cash, Check, Debit Cards, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS. Payment is due on the day of service as this enables us to keep our fees at a reasonable rate.

Insurance - We will file your claim with your dental insurance carrier as a courtesy to you and accept direct payment from your insurance company. However, you must remember that dental insurance is an agreement between you and your insurance carrier. We suggest that you contact the customer service number listed on your insurance card *prior* to being seen in our office. Please also understand that we do not participate with all insurance providers. If for ANY reason your insurance carrier rejects your claim, you are responsible for the balance. ALL INSURANCE CO-PAYS ARE DUE ON THE DAY OF SERVICE.

Payment Plans - We offer extended payment plans through a dental credit company. You must complete an application and it will be submitted electronically for approval. We can usually receive an answer in a few minutes. Please ask for an application.

Missed Appointments - Please try to schedule your appointments at a time that you know is best for you. Once an appointment is made, we require **at least 24 hours in advance notice** if you need to cancel or reschedule. Failure to provide adequate notice may result in a $30.00 charge per half hour booked. We realize that emergencies and illnesses happen; however, the time reserved for you could be given to another patient waiting for an appointment.

Additionally, if a patient misses three (3) appointments without calling to reschedule and/or canceling without, at least, 24 hours advance notice, we will not offer any additional appointments to the patient. The patient's care will be transferred to another practice. We will ensure that this transfer is accomplished without disruption to ongoing treatment.

Additional Charges - Any balance not paid within 30 days of presentment will incur finance charges of 1-1/2% interest per month (18% APR). In the event of a default in payments, Patient will be liable all amounts due; for any court costs and reasonable attorney's fees incurred in collecting past due amounts and for a collection fee equal to 33% of the judgment amount for damages, court costs and attorney's fees. Our returned check charge is $30.00.

I hereby authorize William H. Walls, D.D.S., P.C. to furnish information to my insurance carrier concerning my condition and treatment and I do hereby assign the doctor all payments for dental services rendered to my dependents or myself.

After reading all of the information on this form, I understand the terms and give my authorization and consent by signing below.

Patient's Name: (Please Print) _____ Date_____

Patient's Signature: _____

Parent, Guardian or Responsible Party: _____