WRIGHT DENTAL CENTER

3760 Alexandria Pike, Cold Spring, KY 41076

859-441-3120 Phone 859-908-3424 Fax

www.wrightdentalcenter.com

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Or fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is and agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment.

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, and American Express. In addition, we offer CareCredit and Lending Club, these are both patient payment programs offering a full range of No Interest and Extended Payment Plans. Payment for services is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $50.00 returned check fee. This fee covers the processing fees that are charged to our office.

Refunds for over payment will be sent after all treatment is completed and insurance has been collected.

RESCHEDULING/CHANGE IN SCHEDULE POLICY

Our practice is dedicated to quality care and exceptional service. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other clients. If proper notice is not received there is a one time courtesy for not showing up for scheduled appointment. Repeated cancellations or missed appointments will result in a fee of $50.00.

I have read and agree to the Financial Policy and the Cancellation Policy of Wright Dental Center.

Name of Patient (Print)_____

Signature of Patient or Responsible Party_____