

**W Dental Group
8744 Grissom Rd.
San Antonio, TX 78251**

NO SHOW AND LATE CANCELLATION POLICY

Due to the large increase in the number of people not attending their appointments and not calling to cancel in a timely manner, I have regretfully been forced to change my policy concerning No Shows and Late Cancellations.

Our office uses an automated email reminder system as well as a courtesy phone call two days in advance to help you manage your appointments. This is offered as a courtesy. REGARDLESS of whether or not you receive a reminder call, you are responsible for attending your appointment or canceling at least 48 hours prior to our last business day.

I understand there are **RARE** times emergencies interfere with appointments, however, too often an appointment is not attended because, it suddenly becomes inconvenient. This not only radically impacts my practice negatively, but it prevents other people, who are eager for dental care from having that appointment time. Please let me know as soon as possible if a rare emergency is the case, so that you can be rescheduled to another time slot.

1. After the first No Show all future appointments already scheduled will be cancelled.

After the second late cancellation all future appointments will be cancelled.

You will be free to make one appointment with me after each appointment you attend.

Multiple appointments that are scheduled on the same day will not be allowed to schedule more than one appointment at a time.

Any appointment that is scheduled during prime time (3:00 p.m.-5:00 p.m.) and is a No Show or Late Cancel will not be permitted to schedule during this time without my permission.

2. Per the agreement you signed at the start of treatment, all No-Shows and Late Cancellations will result in a \$50.00 preparation fee charged to your account. You will be responsible for paying this or making a payment arrangement with me. Your insurance will not cover this fee.

You may secure your next appointment with a deposit of \$50.00 up to the full fee of the procedure(s) scheduled for the next appointment by credit card, which is non-refundable.

3. If you No Show or Late Cancel 3 times in any 3 month period, I will reserve the option to assist you in finding another provider who can meet your dental needs.

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FINANCIAL POLICY

Our mission is to deliver the finest Dental Care possible, performed to your satisfaction. Payment is due at the time of treatment. If this is not convenient for you, we have two monthly payments plan called **Capital One Healthcare Finance and Care Credit**, which allows you to start your treatment and spread the payments over time. We offer three payment options: 1.) Cash, check, or debit card; 2.) MasterCard, Visa, Discover; or American Express 3.) Capital One Healthcare Finance and Care Credit. An application for this plan only takes a few minutes to fill out and we will be glad to process your application immediately. There is no cost to apply and offer convenient payments.. **When you are approved funds are available for your immediate use.**

IT IS YOUR RESPONSIBILITY TO PAY FOR SERVICES AT THE TIME YOU RECEIVE THEM, regardless of any dental insurance benefits you have. Unpaid balances are subject to a \$5.00 billing fee after 60 days. If it becomes necessary to forward unpaid balances to an outside collection source a service fee of \$50.00 will be charged to your account.

In an effort to make dentistry more affordable to you, we participate with certain Dental Insurance Programs. Dental Insurance allows for your reimbursement of a percentage of fees for service. We will help you receive maximum benefits under your policy. **Please remember that the amount of insurance coverage is only an estimate. The patient is responsible for all treatments or charges not covered by insurance.** If we accept benefit assignment, as a service to you, we ask that you provide complete insurance information and pay your deductible amount and estimated portion at the time of service (some procedures require 50% or more payment). **The patient portion is an ESTIMATE ONLY.** If your insurance company has not paid the **FULL BALANCE** within 45 days, you will be given 15 days to complete payment or make financial arrangements of the balance. Late payment charges will be added to the unpaid balance after 60 days from the date of service. If your insurance pays more than the balance due, we will send a refund check to you at your request, or credit patient/family account. **Insurance is never a guarantee of payment of benefits; therefore, service not covered or denied for any reason will be your responsibility.**

Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract except for **United Concordia, Delta Dental Preferred, and Connection Dental.** We file claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information. An insurance company's usual and customary fee **MAY NOT** be our office fee. Patients will be responsible for any amount not covered by their insurance. This is **YOUR** insurance plan. If you have any questions regarding your coverage, please contact your insurance company or your employer's Human Resources representative. **YOU** are **ALWAYS** responsible for the timely payment of your account.

Please indicate by your signature below that you understand and agree to abide by this Financial Policy. If you have any questions or concerns regarding this Policy before you begin your treatment, we are here to serve you and are happy to help.