westervilledentalassociates

627 Office Parkway
Westerville, Ohio 43082
(614) 882-1135

FINANCIAL POLICY

We are committed to providing you and your family with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our policy regarding payment for services and dental insurance.

- Payment is due as services are rendered. We accept VISA, MasterCard, Discover, American Express, Care Credit, Cash and Personal Checks.
- If you have provided us with **complete insurance information** at time of service, we will estimate your portion due and you will be asked to pay at time of service.
- We must emphasize that as health care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients. In order to do this, we must have complete and accurate information regarding your insurance.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or fees they will not cover, the balance of your account or any part thereof, is your responsibility from the date that services are rendered, regardless of insurance.
- A fee will be applied for cancellations with less than 24 hours notice.

Policy Regarding Minor Children

Parents of minor children are responsible for our services rendered to the children regardless of insurance coverage or court order. We are not a party to the court order, and while we will attempt to cooperate with handling of a difficult situation, the parent bringing the child to the office will be ultimately responsible for the account.

Authorization and Release

I authorize Westerville Dental Associates LLC to perform diagnostic procedures and treatment as may be necessary for proper dental care for me or my child/children. I authorize release of any information concerning me or my child's dental care, advice and treatment to another dentist. I authorize release of any information concerning me or my child's dental care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group. I understand that my dental insurance carrier or payer of my dental benefits may pay less than actual bill for services, due to our office being non-participation provider. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of service not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this document.

PATIENT / Guardian sign Date