Westervelt
FAMILY DENTISTRY

Kirk W. Westervelt, DMD

Welcome to our practice! Thank you for choosing us as your dental health care provider. We are committed to providing you with the best possible treatment utilizing the latest techniques, materials, and instrumentation that will allow us to deliver this care in a most cost-effective, efficient, and comfortable manner.
Regretfully, past experience has forced us to be very clear and precise with respect to our financial policy which we require you to read and sign prior to any treatment.

Our Financial Policy

1. Please understand that payment of your bill is considered a part of your treatment and is DUE AT TIME OF SERVICE.
2. We except Visa, Mastercard, Discover, American Express for your convenience and Care Credit (healthcare credit card) if monthly payments are needed with zero financing.
3. Regarding Insurance:
   A. We will submit your Insurance claims as a courtesy to you, but we cannot do so unless you provide us with your Insurance card, front and back.
   B. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is the patient who receives our services not the insurance company. The financial responsibility for our treatment lies with the patient.
   C. We will estimate your portion as best we can and will need a credit card on file to use once the Insurance company has paid your claim.
   D. Please be aware that, depending on your particular plan, some procedures may not be covered.
   E. Our commitment to you is to provide you with the best possible treatment. To avoid surprises on your bill, it's important to understand what and how much your plan will pay.
4. Missed Appointments and collections:
   A. Unless cancelled at least 24 hours in advance, our policy is to charge $50 for missed appointments.
   B. All accounts over 90 days past due will be turned over to collections.

Thank you for understanding our financial policy. It is unfortunate that we have to be so specific, but past experience has left us with no other choice. Please let us know if you have any questions.
I have read the financial policy above, and I understand and agree to its terms.

x_____ Date:_____

Patient Signature