Winter Street Dental Group

Financial Agreement

Payment is due at the time of service. As a courtesy to you, our office will verify your dental benefits, however, it is ultimately your responsibility to know what your insurance covers. We will submit the charges to your insurance company. If payments are denied; you will be responsible for the balance. Insurance is designed to cover a portion of our fees only. Your co-pay, which is estimated, is collected at each appointment. I authorize my insurance company to pay Winter Street Dental directly. Initial here. _____

Cancellation and Failure to Arrive

We understand that circumstances do arise that can keep you from your dental appointment. We require 48 hour notice to change/cancel ANY appointment. If you fail to show up for a hygiene appointment, a fee will be assessed after the second failure. If an appointment needs to be change after the 48 hour requirement period for the notice, you will also be charged accordingly any appointments more than 45 minutes long, will be charged $60 per 30 minutes of scheduled time. Initial here. _____

Specialist Cancellation Fee

There will be a $150.00 deposit due at scheduling of a specialist appointment. This includes appointments with the Periodontist, Oral Surgeon and Endodontist. This fee will be credited to your account as part of the copay due at the visit. Should the patient cancel within the required (3 day or 72 hours) notice, the deposit will be charged as the cancellation fee. Initial here. _____

Appointment Reminder Cards

I give Winter Street Dental Group permission to send a reminder postcard through the U.S Postal Office.

Initial here. _____

X-Ray

Original x-rays are the property of Winter Street Dental Group. If you wish to have your x-rays duplicated, there will be a $25.00 processing fee. A notice of 72 hours is required prior to picking up or mailing out x-rays.

Initial here. _____

Collections

If you fail to pay your balance after 90 days, your account will be sent to a collection agency. There will be a $25.00 charge to process the collection account and a 20% collection cost added. Initial here. _____

By signing below, I understand and agree to the above listed office policies of Winter Street Dental Group and assume responsibility for all services rendered.

_____ ____/____/____

Patient/Parent or Guardian Date