VALERIE A. WYNNE-HALL, D.D.S., M.P.H., P.A.

FINANCIAL POLICY AND ASSIGNMENT OF INSURANCE BENEFITS

The intent of this document is to inform you of Dr. Wynne-Hall's Dental Practice financial policies. We are committed to providing you with the best possible care and service; therefore, your complete understanding of theses policies as it relates to your financial obligations is essential. Please read carefully. Initial each section to show acceptance and acknowledgment.

I. ALL PATIENTS

a. Total payment for services performed must be paid in full at the time of service on the day of appointment.
b. We accept; cash, personal checks, debit cards, Master Card, Visa, American Express, Discover, Care Credit, Money Orders, and Traveler's Checks as payment for services rendered.
c. A $35.00 returned check fee will be charged to your account for each check returned for insufficient funds, stopped payment or account closed.
d. A fee of $35.00 will be charged to your account for each broken appointment or appointments not canceled within a 24 hour period. Broken appointment fees are not file able to Insurance Companies and are the responsibility of the patient.
e. Any past due balances are subject to additional late fees. Balances not paid within 120 days or non compliance with this financial policy may be turned over to a collection agency for final dispensation.
f. Patients eighteen years or older are legally responsible for all charges incurred unless covered by parent's insurance and documented as a beneficiary of the parent's policy.
g. Patients under the age of eighteen are not legally emancipated and will not be treated unless the parent or legal guardian is present for the appointment.
h. This office will not become involved in divorce or separation issues. Any patient under the age of eighteen, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred, regardless of the name of the subscriber parent listed on the child's insurance card.
i. Additional fees, up to $35.00 will also be charged to your account if we are asked to participate in a deposition or to produce, with proper authorization, dental records for your insurance company or attorney.
j. Dr. Valerie Wynne-Hall's Dental Practice will not become a third party to claims related to motor vehicle accidents or liability. Expenses related to dental treatment that are a result of such accidents are the full responsibility of the patient and due at time of service.

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II. ATTENTION: UNITED CONCORDIA AND DELTA PREMIER PATIENTS

a. We are currently approved providers for **Tricare-United Concordia and Delta Premier Insurance Policies** and will file all claims for those policy holders.
b. As approved providers for United Concordia and Delta Premier we accept as payment the amount of coverage your particular plan will pay.
c. **All** deductibles, co-payments, and coinsurance are due at the time of service for **all patients for all insurance policies**.
d. Any service that an insurance company deems as "none covered" is the full responsibility of the patient and is due in full within 30 days after receipt of the billing statement.
e. Delayed or non-paid claims by your insurance company are the responsibility of the patient and not the office of Dr. Wynne-Hall.

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III. INSURED PATIENTS – ALL OTHER INSURANCE PLANS

a. For all other patients with insurance for whom we are non network providers, we will file your claims as a service to you.
b. Be aware that when using your insurance at an out of network dentist the patient is fully responsible for all uncovered services or excess fees that may be encountered.
c. For patients with Primary and Secondary Insurances both will be filed.

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STATEMENT OF AGREEMENT:

I agree to forever hold harmless Dr. Valerie A. Wynne-Hall's Dental Practice and her staff for refusal to render further services in the event I do not honor this financial agreement. I understand that for any service I do not pay for in full at the time service is rendered that I assign benefits for that claim to Dr. Valerie Wynne-Hall's Dental Practice.

Having read and fully understand the above information, I authorize Dr. Valerie Wynne-Hall's Dental Practice to submit appropriate information to my insurance company for processing of my claim(s).

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Patient's Signature **Date**

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Parent/Guardian Signature (if patient is a minor) **Date**

*While this practice makes every effort to keep patients informed of changes we reserve the right to alter policy without notice.