Jennifer M. Roe DDS FAGD

FINANCIAL POLICY

Wimberley Dental Center and Dr. Jennifer Roe look forward to providing you the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Our practice is dedicated to quality care and exceptional service. Dr. Roe and the Wimberley Dental Center team spend an extensive amount of time preparing for your visit. Our fees are based on the quality material we use and the time, effort and skill required in performing your needed treatment.

Since our practice is also a business with obligations that must be met, payment is due in full at the time service is rendered. Financial arrangements may be made prior to scheduling of your treatment. Payments will not extend after treatment is finished as we do not do long term financing. We do however work with Care Credit as an alternative.

We are not contracted with any Dental insurance and are considered an **Out of Network Dental Provider**. If you have dental insurance, we are happy to electronically submit the claims necessary to help you maximize your benefits. As a courtesy, we will send all dental claims to your insurance company at your request, but we require payment on all services to be paid up front regardless of insurance coverage.

Your insurance policy is an agreement between you and the insurance company, the outlined estimates given on treatment plans are based on the limited information we are able to obtain from your insurance company. We cannot guarantee any estimated coverage. Regardless what we might calculate as your dental benefit dollars, this is not a guarantee of payment. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to understand your dental benefits, the coverage, and exceptions of your particular policy.

If your account becomes delinquent, you will be responsible for any legal cost or collection charges. Checks that are returned to our office from your financial institution are subject to a $40.00 returned check fee. This fee covers the processing fees that are charged to our office.

I, _____ have read and understand Wimberley Dental Center Office Policy regarding payment and insurance. For individuals with insurance, your signature below hereby authorizes the doctor to release any information required for payment and processing of your claim. Please sign below to acknowledge you understanding of the information contained herein.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN TODAY'S DATE

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PRINTED NAME OF PATIENT