EDWARDS & WILSON PERIODONTICS, P.A.
4830 QUAIL CREST PLACE
LAWRENCE, KS 66049
785.843.4076

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, OR YOUR RESPONSIBILITY. PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, MASTERCARD, VISA, DISCOVER, AND CARE CREDIT.

[1.] IF INSURANCE IS INVOLVED, CO-PAYMENT AND ANY DEDUCTIBLE IS TO BE PAID AT THE TIME SERVICES ARE RENDERED.
[2.] PAYMENT PLANS MAY BE ARRANGED IN ADVANCE BASED UPON ESTIMATED FEES, SUBJECT TO CREDIT APPROVAL.
[3.] FAILURE TO ADHERE TO AGREED UPON PAYMENT ARRANGEMENTS WILL REQUIRE FULL PAYMENT OF CURRENT CHARGES AND ADVANCE PAYMENT OF ANY FUTURE SERVICES.
[4.] THE PARENT OR GUARDIAN WHO ACCOMPANIES A MINOR TO THE APPOINTMENT IS FINANCIALLY RESPONSIBLE FOR THE ACCOUNT.
[5.] WE REQUIRE 48 HOURS NOTICE FOR ANY CHANGE OF APPOINTMENT. FAILURE TO COMPLY MAY RESULT IN A FEE TO REAPPOINT.
[6.] HAVE YOU FILED BANKRUPTCY IN THE PAST 10 YEARS OR ARE YOU IN THE BANKRUPTCY PROCESS AT THIS TIME YES / NO

WE FILE INSURANCE AS A COURTESY TO OUR PATIENTS. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOUR BENEFITS DEPEND ON WHAT YOU OR YOUR EMPLOYER NEGOTIATED WITH THE INSURANCE CARRIER. IT IS IMPOSSIBLE FOR US TO HAVE COMPLETE KNOWLEDGE ABOUT THE NUMEROUS DENTAL AND MEDICAL INSURANCE COMPANIES CONTRACTS WITH EMPLOYERS OR YOUR STATUS WITH YOUR PARTICULAR COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY INSURANCE, OR OTHER MATTERS REGARDING REIMBURSEMENT. IF ACTION BECOMES REQUIRED TO COLLECT A DEBT, YOU WILL BE RESPONSIBLE FOR ANY AND ALL COURT COSTS INCURRED IN THE PROCESS.

I UNDERSTAND I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT REGARDLESS OF WHAT MY INSURANCE CARRIER MAY OR MAY NOT PAY. THIS SIGNATURE WILL ALSO SERVE AS SIGNATURE ON FILE FOR ASSIGNMENT OF INSURANCE BENEFITS. I AUTHORIZE RELEASE OF INFORMATION RELATING TO INSURANCE CLAIMS.

* IF THE PATIENT IS OVER 18 AND ON A PARENT'S INSURANCE POLICY, THE PARENT MUST SIGN THE FINANCIAL POLICY.

PATIENT SIGNATURE ____ DATE _______________
[GUARDIAN]

PATIENT NAME

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POLICY HOLDER NAME [IF DIFFERENT]

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POLICY HOLDER DATE OF BIRTH

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INSURANCE CARRIER NAME & ADDRESS

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