Financial/Insurance Policy

Thank you for choosing Dr. Marshall L. Wallace as your dental health care provider. Our mission is to deliver the finest, most cost-effective health care treatment available for your needs. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in todays and future treatment. Your clear understanding of our patient's financial responsibility is important. Please ask if you have any questions about our fees, policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes.

Please be advised that this office does not participate with Medicare or Medicaid plans. We are unable to bill or collect any reimbursement for treatment that you receive in this office.

PAYMENT OPTIONS
Payment is due at the time services are rendered. We accept Cash, Personal Check, Visa, Mastercard, Discover and American Express. We also accept CareCredit.

INSURANCE
WE ARE AN OUT OF NETWORK DENTAL OFFICE meaning we are not a participating provider with any insurance company. As a courtesy to our patients, we will gladly process your insurance claim. Please be aware that some or perhaps all of the services provided may be non-covered services by your insurance. We cannot guarantee what your insurance company will pay. If payment for services already rendered has not been paid within 45 days by your insurance company, the remaining balance for treatment is considered due and collectible and you will be asked to make payment in full.

MISSED APPOINTMENTS/CANCELLATIONS
We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A 48-hour notice is required for cancellation of appointments. We reserve the right to charge a $50 fee for broken appointments or ones that are not cancelled beforehand within a reasonable time frame. If repeated 'no shows' occur, you will be discharged from our care.

ADMINISTRATION FEES (If Applicable)
Checks that are returned to our office from your financial institution are subject to a $35 returned check fee.
If collection and/or legal services are required to obtain payment, an additional fee of $150 will be charged to your account. This will cover collection agency fees, attorney fees, and court costs. This will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

I understand and accept the financial and the dental insurance policies listed above. **I agree** to pay for all treatment in a timely fashion to avoid any additional fees. I hereby authorize my insurance benefits to be paid directly to Dr. Marshall L. Wallace. I realize that I am responsible to pay for any deductible amount, my co-insurance portion, and any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by my insurance and I agree to pay such charges in full.

_____ _____
Patient (or Responsible Party) **Date**

_____ _____
Office Manager **Date**