TeethWise Dental

TeethWise Dental
3809 Atascocita Rd.
Suite 700
Humble, Texas 77396

OUR FINANCIAL POLICY:
We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relation. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

MINOR UNDER 18 NEEDS TO BE ACCOMPANIED BY AN ADULT

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, PLEASE READ CAREFULLY!!!
If you have insurance, we will assist you in receiving maximum benefits. As a **courtesy** we will call and verify your insurance and file claims. Verified insurance is not a guarantee of payment. On all services, we may accept your insurance if approval is obtained prior to the date of service. If we accept your insurance, you must pay deductible and co-pay at time of service. Patient is responsible for any payment not made by insurance company; our services are rendered to the patient not the insurance company. We are not a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc. **Patient is responsible for difference between Amalgam and Resin fillings. Most insurances Do Not Pay For Resin (white) filling. PATIENT IS RESPONSIBLE FOR ANY PROCEDURES NOT COVERED OR OVER THE MAXIMUM ALLOWANCE.**
I release any and all information needed to submit and collect on all insurance claims. I release payment from insurance company to Dr. Ladipo's office.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. Any financial arrangements existing more than 90 days will be subject to fees. **There is a $25.00 fee for all appointments not canceled 24 hrs prior to appointment time.** Insurance assignments are accepted for a period not to exceed forty-five days. If the insurance has not paid within forty-five days of filing the insurance, the patient is expected to pay the balance in full.
PLEASE INITIAL AFTER READING: _____

A non-refundable deposit of $50 will be required to schedule surgeries. The deposit will be applied to patient service cost related to the scheduled surgery. Surgeries canceled less than 48 hours prior to the date of surgery will forfeit the deposit.

I have read and understand The Financial Policy.

_____ _____
Patient/Guardian Signature Date

HIPPA
This is only an acknowledgement that I have been provided a copy (please ask someone in the front office for a copy) of the NOTICE OF PRIVACY PRATICES (HIPPA) for review. I also understand if I would like a copy of my own I must request it.

_____ _____
Patient/Guardian Signature Date

We will request to take your picture for our records. The photo will be used for internal office purposes only for patient identification. This photo will not be used for marketing or any other reason.