

WEST CARY DENTAL
Dr. Amit V. Patel, D.M.D., P.A.
351 Wellesley Trade Lane, Suite 211
Cary, NC 27519
919-363-9887
westcarydental.com

FINANCIAL POLICY

In order to deliver comprehensive dental care for you and your family, it is important to control cost. We expect each patient, parent, or legal guardian to accept financial responsibility of the fees involved in the dental treatment of you and your family. Please read the financial information and sign. If you have any questions, please feel free to ask our staff.

1. We recommend the best dental care for you, regardless of dental insurance limitations.
2. Your insurance is a contract between you, your employer and the insurance company.
3. Co-payments and deductibles (for those with insurance) or full payment for those without insurance is due at the time of service.
4. You are responsible for all charges regardless of estimated insurance coverage. Claims not paid after 45 days will be billed to you for payment.
5. A finance charge of 1.5% (18%) is added to all balances greater than 90 days old. If we must pursue payment through our attorney for collections, you will be responsible for all added fees.
6. There is a **\$30** charge for all returned checks.
7. There is a **\$50** charge for short notice or less than 24 hour cancellations or no show appointments. **It is your responsibility to remember your appointment time.** However, if time permits we will remind you with a courtesy call.
8. Any appointments **15 minutes late** or more will be rescheduled and charged a fee.
9. Please be courteous and turn off your cell phones and do not use them in the office. It limits our treatment time we have scheduled for you and other patients.

I understand and agree to all terms of this financial policy. A copy of this policy will be provided to you at your request.

I hereby authorize West Cary Dental, Dr. Amit V. Patel, DMD, PA to submit insurance claims and assign benefits to my insurance company electronically or by postal service, on my behalf.

Patient____ Parent ____ Guardian____ Relationship to patient (if not self) _____

Signature _____ Date _____

Office Personnel _____ Date _____