Financial Policy

Thank you for choosing West Ashley Family Dentistry. We look forward to serving you with the best dental care and service possible. If you have any questions regarding payment options, insurance or payment amounts, our financial coordinator is happy to assist you.

Payment Options

We request payment on the date of service unless other arrangements have been made. We accept cash, check, and credit cards (VISA, Mastercard, and Discover) as payment. Should you need assistance with your payments we also accept CareCredit, a medical and dental credit card that allows you to pay over time often with no interest. For some procedures payment is required 48 hours in advance to reserve your appointment time.

Insurance

We are happy to pre-estimate and file your insurance for you. If your insurance company allows assignment of benefits to our office, you are only responsible for the portion that insurance does not cover on the day of service. If assignment of benefits is not allowed by your insurance company, we will still file your insurance for you however the full fee will be due on the day of service and your insurance company will reimburse you directly. Please remember that your patient portion has been estimated from information that your insurance company provided to us and is only an estimate. Should your insurance pay less than the pre-estimated amount the balance is your responsibility.

Missed Appointments

We understand that from time to time it is necessary to reschedule an appointment. We request that you give us 24 hours notice if this is necessary to allow us to offer this appointment to another patient. Last minute cancellations and patients who miss scheduled appointments without notification create costly waste of supplies and patient care time. We do not want these costs to be passed on to our patients, therefore a $50 missed / broken appointment fee will be charged for those appointments that are missed or cancelled with less than 24 hours notice.

Please let us know if you have any questions regarding these policies. Please sign below to indicate that you have read our financial policy. Thank you!

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Patient Name (print)

______________________________ ____________

Patient Signature Date