

**Wilsonville Dental Group**  
**29292 SW Town Center Loop E**  
**Wilsonville, OR 97070**  
**503-682-0431**

## **Financial Policy**

Thank you for choosing Wilsonville Dental Group. Our doctors and team believe in giving you the best dental care and want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan as well as our financial policy.

### **Do You Accept My Insurance? How Much Will They Pay?**

We currently work with most private dental benefit plans. The amount of coverage that your benefit plan provides is negotiated between your employer and the insurance company. Payment of benefits are never guaranteed by the insurance companies. Therefore, it is impossible to give you a guaranteed quote prior to or at the time of service, even if the services are preauthorized. We estimate your portion based on the most up-to-date information we have, but it is still only an estimate. We will always make every effort to collect the full portion due from your insurance company.

We accept and bill your insurance claiming assignment of benefits. What this means is your insurance will pay our office directly and we will apply it to your claim accordingly. If your insurance does not accept assignment of benefits and pays you directly, it is your obligation to forward that payment to our office to assign their portion of the claim.

### **My Insurance Did Not Pay Now What?**

Please keep in mind that a dental benefit plan is a contract between you, your employer, and the insurance company. We will bill your insurance company as a courtesy to you; however, while we will always make every effort to help you understand your plan, it is your obligation to know your insurance plan. We will allow your insurance company 90 days to pay on claims. After that time you will be billed for all unpaid charges.

### **Minor Patients**

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service has been verified.

In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains the responsible party. After a divorce or separation, the parent authorizing the treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

We are unable to place a parent or guardian on an account, as the responsible party, without the express, written authorization from that parent.

**Financial Options**

**1. Your estimated portion is due at the time of service. We accept cash, checks, Visa, MasterCard, Care Credit and Chase Health Advance.**

**2. Pre-payment:** For our patients who pay their estimated treatment fee in full, by cash or check, at least 48 hours prior to their appointment, a 5% courtesy will apply. This pre-payment and subsequent courtesy adjustment does not guarantee the fee for services should the recommendations change during the course of treatment.

**Finance Charges:** All past due balances (60 days and greater) are subject to finance charges of 12% APR, or a minimum of \$5 per month. This is to offset the costs associated with repeated billing statements.

**Broken Appointment Fee:** A fee of \$50 is charged for appointments missed or broken with less than 24 hours notice. Your appointment time is reserved for you and without notice in advance we are generally unable to make use of the missed appointment time.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

**Signed:** \_\_\_\_\_  
(Patient/Guardian)

**Date:** \_\_\_\_\_

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\*If you have questions regarding our financial policy, please call our office @ 503-682-0431, or you may email us at [finance@wilsonvilledental.com](mailto:finance@wilsonvilledental.com).