Eric R. Wiitala, DDS
Family and Cosmetic Dentistry

PAYMENT AND INSURANCE POLICIES

The following is a statement of our financial policy. Please review and sign prior to treatment being rendered.

If you are a patient without insurance or using a discount plan, you will be responsible for payment of your account in full either in advance or at the time of service.

If you are a patient with insurance, you understand that this insurance policy is a contract between you and your insurance company. It is your responsibility to know the particular coverage pertaining to deductibles, co-payments, patient portions and provider lists.

We agree to process all primary dental insurance claims and any secondary dental insurance claims for any PPO or indemnity dental plans. Payment of benefits will be assigned to our office as the insurance portion of payment for the services provided. If your insurance company has not paid your account in full within 60 days, the full balance will be transferred to you. We do not accept or process HMO or DMO dental plans. We do not process claims to medical insurance carriers.

Once we have received the Explanation of Benefits (EOB) and payment of benefits, we will determine whether any remaining balances are your responsibility. A statement will be issued to you and these balances will be due immediately upon receipt. Please be aware that your insurance company may determine that benefits will not be paid for some services.

Pre-determination of benefits does not guarantee payment of benefits. You will be solely responsible to pay in full for any services that the insurance company denies payment.

You are responsible for payment of patient portions and insurance deductibles at the time of service unless other arrangements are made in advance. Discounting or waiving the patient portion is considered fraudulent practice and will not be offered under any circumstances.

Parents or guardians accompanying a minor patient are responsible for payment of the account at the time of service.

Treatment over $1000.00 will require a scheduling deposit of $100.00. Said deposit will be applied to your treatment. If an appointment is cancelled or rescheduled with less than 48 hours notice this deposit will not be refunded.

PATIENT PAYMENT OPTIONS

1. FOR PATIENTS WITH NO DENTAL INSURANCE-PAYMENT IN FULL AT TIME OF SERVICE RECEIVE A 5% DISCOUNT. THIS DISCOUNT APPLIES ONLY WHEN USING CASH OR CHECK _____
2. FOR PATIENTS WITH DENTAL INSURANCE-PAYMENT IN FULL FOR PATIENT PORTION ON DAY OF SERVICE _____
3. THIRD PARTY FINANCING FOR PAYMENT OF PATIENT PORTION AT TIME OF SERVICE_____

I UNDERSTAND THAT THE FEE BREAKDOWN PRESENTED IS AN ESTIMATE ONLY.

I HAVE READ THE ABOVE POLICY AND HAVE SELECTED A PAYMENT OPTION. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY DR. ERIC WIITALA. I AUTHORIZE RELEASE OF PATIENT INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENFITS TO DR. ERIC WIITALA. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

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Patient Signature Dated