

Dentistry at Westland

33725 N. Scottsdale Rd. | Scottsdale, AZ 85266 | 480-585-5215

Financial Policy

Thank you for choosing Dentistry at Westland for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. In order to provide you with the highest quality dental care, we will provide you with a treatment plan which includes an estimate of fees. You are responsible for payment prior to the beginning of all treatment. We will file all necessary claims to your insurance carrier as a courtesy to you. If we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of treatment fees or interest will be applied to your account at a rate of 1.5% per month.

Payment Options

- * Cash, Check, Visa, MasterCard & American Express
- * Courtesy Credit of 5% to patients who pay for their treatment in full with cash or check prior to beginning treatment of \$1,000 or more.
- * CareCredit –No Interest payment plan with no annual fees or pre-payment penalties

We believe that it is your responsibility to complete treatment and follow a recommended dental maintenance schedule. If treatment plans are not followed and appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatments for the involved teeth, etc. can be affected.

_____ (Initials) I understand the above information

Appointment Commitment

If it is necessary for you to change your scheduled appointment, we request that you give us 48 hours notice. There will be a fee of \$50.00 per missed appointment.

_____ (Initials) I understand the above information

Insurance Policy

Please be informed that dental insurance is a contract between you and your insurance company. **We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions.** We, at Dentistry at Westland are providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please provide us with a copy of your insurance card and benefit booklet (if available) at your first visit or when your dental coverage changes. Please be aware that your insurance may have a yearly maximum and anything over that amount will be your responsibility. **It is your responsibility to provide us with any future changes in your insurance.**

_____ (initials) I understand the above information

If you have any questions, please do not hesitate to ask. We are here to help you receive the dentistry you want and need.

I understand and agree to the above policies.

Signature of Patient, Parent or Guardian

Date

