1655 WAKE DRIVE - SUITE 102
WAKE FOREST, NC 27587
TELEPHONE (919) 570-2845

Financial Policy

Thank you for choosing our office to care for your dental needs. Our practice is committed to providing you with the highest quality of dentistry in a comfortable and friendly atmosphere.

For Our Non Insured Patients

If you do not have dental insurance, payment will be required in full at time of service. We offer a 10% discount to patients without dental insurance. In addition we offer Care Credit to our patients to help fit your treatment fees into your budget. With Care Credit you can get up to 12 months with no interest. We will coordinate with Care Credit to confirm your financing eligibility.

For Our Patients with Dental Insurance

We file insurance as a **courtesy** to our patients and require that benefits be assigned to our office. Our staff will assist you in obtaining maximum dental insurance benefits, and will verify the coverage that your particular program provides. I understand my dental insurance is a contract between the insurance carrier and me, not between Wake Forest Smiles and the insurance carrier. Therefore, I am responsible for all dental fees. I understand that the estimated insurance benefits are only estimates. Final determination of benefits is made by the insurance company once the claim has been submitted. Any fees not paid by my insurance 60 days after treatment is rendered are my responsibility.

We will not file secondary insurance but will gladly guide you through this process.

We make every effort to keep down the cost of your dental care. **All co-pays and deductibles are due the day services are rendered.** We accept cash, personal check, Visa, Master Card, Discover, and American Express.

The patient or responsible party will assume all cost of collection.

For Our Minor Patients

The adult parent or guardian accompanying the minor is responsible for payment. For unaccompanied minors treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment.

Please be advised that we require at least a 24 hour notice when canceling or rescheduling an appointment to avoid a $50 fee.

All returned checks are subject to a $35.00 service fee.

Photo identification required.

MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

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Signature of Patient or Guardian Date