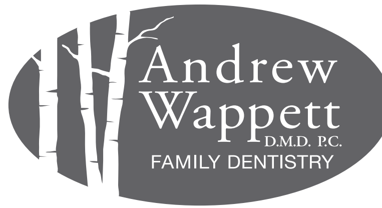

AUTHORIZATION, RELEASE and FINANCIAL POLICY

I authorize Andrew Wappett DMD PC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. If benefits of services are sent to me, such checks are to be endorsed to Andrew Wappett DMD PC as payment on my account.

I am aware that my dental insurance coverage benefits are between myself and my employer and as a courtesy Andrew Wappett DMD PC will submit dental claims on my behalf or my dependents to my insurance company. Although we maintain computerized histories of payment by several companies, payment of benefits is never guaranteed by insurance companies. Therefore, it is impossible to give you a guaranteed quote prior to or at the time of service, even if the service is preauthorized. We estimate your portion based on the most up-to-date information we have, but it is still *only an estimate*.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents including any co-payments and deductibles that my insurance does not cover. I am aware that payment of my estimated co-insurance portion is expected at the time of service. We accept cash, checks, and credit cards (Visa, MasterCard and Discover). We also offer extended pay options, pending your approval, through third party dental care financing companies.

I am aware that any unpaid balance that my insurance company does not cover must be paid in full within 30 days. All past due balances (30 days and greater) are subject to finance charges at a percentage rate in accordance with Alaska state law. This is to offset the costs associated with repeated billing statements. I am aware that failure to make my payments as agreed upon may result in legal or collection action to recover said amount and any legal fees, court costs, and /or collection fees incurred in this process will be added to my account balance. Fee schedules are updated annually in January.

In addition, any appointments cancelled or broken with less than 48 hour notice will be charged a $50.00 cancellation fee per hour scheduled. Your appointment time is reserved for you and you alone, and without notice in advance we are generally unable to make use of missed appointment time. Because our office is maintained on a tight schedule, arriving late for an appointment may result in us not being able to start or complete treatment in the remaining amount of time. To provide you with proper dental care, it may be necessary to reschedule your appointment. We will consider you late if you arrive **10 minutes** or more after your scheduled appointment time. **Two** successive late or broken appointments constitute grounds for dismissal from the practice.

I authorize copies of this form to be as valid as the original.

X____ **Date**___________________

Signature of Patient (Parent/Guardian if patient is a minor)