TIMOTHY G. WILSON, D.D.S., P.C.

Financial Policy

Payment for services provided is due at the time services are rendered. We accept the following forms of payment: Cash, Check, Visa, Mastercard, and Discover Card. Charges will be applied for returned checks.

Finance charges will be applied on all accounts beginning 60 days from the day services are rendered. Charges are computed at the rate of 1.5% per month, an annual percentage rate of 18% (or a minimum charge of $3.00 for a balance under $200.00).

The responsible party's account may be assessed a minimum charge of $75.00 for any appointment cancelled with less than 2 business days' notice or for failed appointment(s).
If you have dental insurance, we will submit your claim as a courtesy to you. However,

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2. While filing insurance claims is a courtesy we extend to you, all charges are your responsibility from the date the services are rendered. Regardless of insurance benefit or denial of benefit, you will be billed for any amount not paid by your insurance company that is more than 60 days outstanding.

3. We will estimate your co-pay/deductible for services rendered and pre-treatment estimates based on information provided to us by you and your insurance company.
However, due to variances beyond our control, be advised that these are only estimates. We cannot predict or accept responsibility for any differences in actual insurance reimbursement.

4. Any information provided by your insurance company is neither a guarantee of payment nor a determination of entitlement to certain benefits.

5. Not all services are covered benefits. If you have any questions regarding coverage or insurance reimbursement, you will need to contact your insurance provider.

I have read the financial policy above and understand that I am ultimately responsible for the balance of my account and payment of fees for any professional services rendered. I understand treatment may be postponed or halted if my account is not current. In case of default of payment, I agree to pay interest on the balance due, attorney fees, and the cost of any services necessary for the collection of my account or accounts.

Patient
Name_____Date_____