JAN WESTBERRY, D.M.D WENDY R. WESTBERRY, D.M.D
2234 STATE ROAD 44 NEW SMYRNA BEACH, FL 32168
PHONE: 386-423-1440 FAX: 386-423-1957
EMAIL: JAN_WESTBERRY@BELLSOUTH.NET

2014

FINANCIAL POLICY

- PAYMENT IS DUE AT TIME OF SERVICE.
- IF YOU REQUIRE FINANCING, WE OFFER SEVERAL OPTIONS; PLEASE NOTE THESE ARRANGEMENTS NEED TO BE MADE PRIOR TO TREATMENT.
- A MONTHLY FEE OF 1.5% WILL BE APPLIED TO DELIQUENT ACCOUNTS.

MISSED APPOINTMENT POLICY

- I HEARBY ACKNOWLEDGE THAT I MAY BE CHARGED A NON-REFUNDABLE FEE OF $25.00 FOR A MISSED APPOINTMENT.
- A MISSED APPOINTMENT OCCURS WHEN THE PATIENT FAILS TO NOTIFY THIS OFFICE OF CANCELLATION 24 HOURS PRIOR TO THE RESERVED APPOINTMENT TIME. I ACKNOWLEDGE THAT IF I MISS SEVERAL APPOINTMENTS, I MAY BE REQUIRED TO PRE-PAY FOR MY NEXT APPOINTMENT, OR BE PLACED ON A WILL CALL LIST. (WILL-CALL REFERS TO A LIST OF PATIENTS WHO ARE CALLED WHEN LAST MINUTE OPENINGS OCCUR IN THE SCHEDULE.)

COLLECTIONS POLICY

- I HEARBY ACKNOWLEDGE THAT IF MY ACCOUNT BECOMES SERIOUSLY DELINQUENT, IT WILL BE SENT TO A COLLECTIONS AGENCY.
- I AGREE TO PAY ANY AND ALL COLLECTION COSTS AND ATTORNEY'S FEES ASSOCIATED WITH COLLECTION OF ANY AMOUNT THAT BECOMES DELINQUENT, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 33% OF DEBT.

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

- OUR DOCTOR IS HERE TO PROVIDE YOU WITH THE BEST DENTAL CARE. HER PRIMARY CONCERN IS YOUR WELL BEING, NOT YOUR INSURANCE. THEREFORE, IT IS THE PATIENTS RESPONSIBILITY TO BE AWARE OF WHAT THEIR POLICY COVERS.
- IT IS VERY IMPORTANT FOR YOU TO READ YOUR INSURANCE POLICY VERY CAREFULLY AND PROVIDE US WITH THE MOST ACCURATE INFORMATION SO THAT WE MAY PROPERLY SUBMIT TO YOUR INSURANCE COMPANY. AS WE FILE CLAIMS WITH NUMEROUS INSURANCE COMPANIES AND EACH COMPANY HAS MANY DIFFERENT PLANS, WE CANNOT POSSIBLY BE AWARE OF EACH PATIENT'S PARTICULAR COVERAGE. YOU WILL RECEIVE A BILL IF THE SERVICE IS ONE THAT IS NOT COVERED UNDER YOUR POLICY AND **YOU WILL BE RESPONSIBLE FOR ANY PART OF THE FEE THAT IS NOT COVERED UNDER YOUR POLICY. IT IS VERY IMPORTANT THAT YOU ARE FAMILIAR WITH THE BENEFITS, COVERAGE, AND POLICIES OF YOUR INSURANCE PLAN.**

I HAVE READ THE ABOVE AND UNDERSTAND YOUR POLICY ON MISSED APPOINTMENTS, COLLECTIONS, AND THAT I AM RESPONSIBLE FOR KNOWING THE COVERAGE AND BENEFITS OF MY INSURANCE POLICY.

PATIENT SIGNATURE: ____ DATE: _______________