Kent R. Wildern DDS
4701 Plainfield NE
Grand Rapids, MI 49525
616-364-8716
Fax 364-8829
Website: www.wilderndental.com
Office e-mail: krwdds@msn.com

FINANCIAL POLICY

Dr. Wildern is proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. Following diagnosis, the doctor will advise you of our plan of treatment. Additionally, we will discuss with you the cost of today's and future treatments.

INSURANCE

We will gladly process your insurance claims, estimate your deductible and the portion not covered by your insurance. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by one of the options listed below. The estimates are subject to change depending on acceptance and approval by your insurance company or treatment changes; therefore, the amount due to our office is subject to change. Please contact your insurance company to verify benefit coverage amounts. We are often given the incorrect information or not informed if work has been done in another office. After 60 days, if insurance has not paid, the balance is the patient's responsibility.

If my insurance does not cover its estimate portion, I give Dr. Wildern authorization to charge the remaining balance on the credit card provided at treatment time and on file.

PAYMENT

Payment for today's visit and future visits are due at the time of treatment. We are sensitive to the fact that some people may not be able to pay in cash at the time of treatment. For this reason, we have added Care Credit as an option for treatment payment in our office. We reserve the right to charge interest in the amount of 1.5% (18% APR) on unpaid balances after 60 days.

For services rendered to a minor patient, the adult accompanying the patient, and the parent or guardian with custody will be responsible for the payment.

BROKEN APPOINTMENT POLICY

Our office requires a 24 hour notice for cancellation of an appointment. There is a $50.00 per half hour charge for appointments cancelled or missed without proper notice.

Thank You
Kent R. Wildern DDS

Patient' signature _____

Date_____

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PAYMENT OPTIONS

To help keep the cost of dentistry down, and to continue to provide quality dental care to our valued patients, we now only accept payment in full the day of treatment.

Please check below, the option(s) most convenient for you to settle your account in full today.

A.__ Cash/ Check/ Direct debit (in full) the day of treatment.

B.__ Credit card **/Type ____Card #_____Exp Date_____ 3 Digit Security Code_____**
(Please provide your card so a copy can be made)

C.__ I prefer low monthly payments (see receptionist for applications) Care Credit

I hereby authorize the dental office of Kent R. Wildern DDS to process payments, from time to time, as the dental office deems necessary, to settle/pay my account in full if your insurance doesn't pay what we anticipated.

_____ _____
Patients Signature Date

In the event that your account is placed with a third party collection agency or an attorney, you will be assessed any and all fees that pertain to this collection process.