JC Wolfe, D.D.S., P.C.

Welcome to the office of Dr. J.C Wolfe. We appreciate that you have chosen us as your dental health care providers. Our commitment is to provide you with high quality care in a professional and comfortable environment.

Our Financial Policy

Payment is required before dental services are rendered. For your convenience, we accept VISA, MasterCard, Discover, Personal Check, and Cash. Financing is available for qualified applicants through Care Credit. Please see our financial coordinator for details.

We are committed to providing the best treatment for you, as deemed by the Doctor. Insurance companies may not cover certain services that are deemed necessary for your best oral health. We will continually strive to be knowledgeable in reference to the benefits of your particular insurance policy. Certain insurance companies base their allowances on a fee schedule. Our fees may or may not be the equivalent. You are responsible for the difference. The amount allowed for services listed as a benefit to you is determined by the plan chosen by you and your employer. We make every effort to maintain usual and customary fees in accordance with the area in which the practice is located.

As a courtesy to our patients, we will be happy to verify your benefits for you. If benefits cannot be verified on the first visit, you will be responsible for payment in full at the time of service. If benefits are verified, you are responsible for your annual deductible and your estimated percentage before services are rendered. We recommend that you read your policy carefully to ensure understanding. If you should have any questions or concerns, our trained patient coordinators will be happy to assist you.

We request that any cancellations be made with 48 hours' notice. Failure to notify within 24 hours may result in charges to your account for the time that we have reserved for your care. Failed Appointment charges are billed as follows:

Doctor:	$100.00 per hour
Hygienist:	$60.00 per hour

By signing below you acknowledge that you have read and understand our financial policy and that you agree to allow Dr. Wolfe to address and treat your dental concerns. You also acknowledge that you are ultimately responsible for payment of services rendered regardless of decisions made by your insurance company to either pay or deny claims. Please also understand that we reserve the right to obtain a copy of your credit report. In the event that this office must pursue collection efforts to receive payment, you will be responsible for any costs incurred to include: court costs, attorney's fees, payment of labor for time spent, and any incidental charges. Be aware that collection efforts will also result in negative reporting on your credit history.

By signing below, you also authorize payment of dental benefits directly to Dr. Wolfe.

Signature: _____ Date: _____

Dr.'s Initials: _____ Date: _____

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