Willow Tree
DENTAL
Christopher L. Seese, D.M.D.

Willow Tree Dental Financial Policy

Thank you for choosing Willow Tree Dental as your dental care provider. Our office is committed to providing the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Regarding Payment

To enable you in proceeding without delay, our office offers several financial options. We encourage you to select a financial arrangement that works best for your financial needs.

- Payment is expected at time of service
- An immediate 5% payment courtesy will be given when treatment totaling $250 or more is paid in full by cash or check on the day of service
- We accept VISA, MasterCard and Discover
- Care Credit options are available for qualified patients
- If you have dental insurance, we will do our best to ***estimate*** your copayment. The ***estimated*** copayment will be collected at time of service. As a courtesy, we will file your primary insurance as well as secondary insurance
- For treatment that requires lab work (i.e. crowns, bridges, partials & dentures) a minimum of a 50% partial payment is due at the initial appointment and the remaining balance is due on day of insertion

Regarding Insurance

Your insurance policy is a contract between you and your insurance carrier, not between our office and the insurance carrier. Please understand that some services may be non-covered services and not considered customary under the terms of your dental insurance policy. Our office is committed to providing the best possible care. The patient or guardian will be responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary treatment. Please present and complete all insurance information prior to treatment.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy and understand and agree to said policy.

Signature of Patient/Responsible Party_____ Date_____