Financial Policy & Insurance Disclosure

I understand that payment is due at the time services are rendered unless prior arrangements have been made. I am financially responsible for all fees not paid by my insurance company.

I understand that if my insurance plan does not cover services rendered or pays less than the usual, customary, and reasonable (UCR) fees, I am responsible for the remaining balance.

I understand that any insurance benefit estimates provided by Woodstock Family Dental are estimates only and not a guarantee of payment. Actual insurance payments are determined solely by the insurance carrier and may vary due to plan limitations, exclusions, waiting periods, frequency limitations, or other determinations made by the insurer.

Woodstock Family Dental makes every effort to comply with all insurance contracts in which the practice participates and is legally obligated to follow those agreements. I understand that it is my responsibility to verify network participation, coverage details, and out-of-pocket costs with my insurance company.

In the event of an overpayment, Woodstock Family Dental will issue a refund upon patient request after insurance processing is complete and verification of the overpayment has occurred. If no refund is requested, any verified overpayment will remain as a credit on my account and may be applied to future services.

Initials: _____ **Date:** ____ / ____ / _____