John T. Sox Jr., D.M.D
M. Jacob Wehman, D.M.D
801 True Street
Columbia, SC 29209
(803) 776-2955

FINANCIAL POLICY

PATIENT NAME: _____

DATE: _____

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can. We accept cash, personal checks, or credit cards. (MC, VISA, AMERICAN EXPRESS, DISCOVER and CARE CREDIT).

For our patients with dental insurance, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received.

I, _____, understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or Responsible Party) Signature: _____

Date: _____