



Walter P. Vickers, JR., D.M.D., P.C.
1200 Montlimar Drive
Mobile, Alabama 36609
TEL 251.342.0380
FAX 251.344.3063

OUR FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using on the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Please understand that payment of your bills is considered 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.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. But, as a courtesy to you, we will help you process all your insurance claims.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available through CareCredit upon request and approval. Returned checks and balances older than 60 days will be subject to collection fees.

The adults accompanying a minor and the parents (or guardian of the minor) are responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover, and American Express, or payment by cash or check at time of service has been verified.

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

You agree, in order for us to service your account or to collect monies you may owe, Dr. Walt Vickers and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Dr. Walt Vickers, its employees and/or agents may contact me/us as described above.

(Signature of Patient or Responsible Party)

(Date)

(Print Name of Patient or Responsible Party)



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BROKEN APPOINTMENT/ LATE POLICY

As a dental office, our reserved appointment times are limited and valuable. Your scheduled appointment time is reserved just for you. We try not to overlook appointment times in order to provide excellent dental care and ensure we have sufficient time to adequately treat our patients.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of 24 hours in advance if you are unable to keep your appointment.

It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

Our dental policy stipulates that failure to give sufficient notice to keep a scheduled appointment (1 working day notice) will result in a fee being charged. That charge is in accordance with our dental office's broken appointment policy for all of our patients. The patient is responsible for payment of the charge.

****If you have an e-mail address registered with our office you will be sent an e-mail reminder and you can confirm online. Otherwise, our staff will call one day prior to our scheduled appointment to confirm with you. We will attempt all numbers that you have provided us. If we have to leave a message on your machine or cell phone, it is your responsibility to call us back to confirm your appointment. Remember that we are closed early on Fridays so cancellations of Monday appointments must be called into us on Thursday.**

The usual and customary fee for broken appointments is \$40.00.

Patients who arrive more than 15 minutes late to their scheduled appointment time may be asked to reschedule as a courtesy to our other scheduled patients. _____ (initial here)

Patient Name

Patient, Parent, Guardian Signature

Date