Wagner Pediatric Dentistry, LLC
330 E Silver Spring Dr.
Whitefish Bay, WI 53217
P: 414-939-3870 F: 414-967-4864
office@wagnerpediatricdentistry.com

Financial Policy/Consent to Treatment

Financial Policy

Thank you so much for choosing Wagner Pediatric Dentistry, LLC for your child's dental care. We wish to establish a long and positive relationship with you and your child. Your understanding of and cooperation with the following financial guidelines is appreciated.

If you have dental Insurance: Wagner Pediatric Dentistry, LLC, like most specialty practices, is an out of network provider for dental PPO and HMO insurance carriers. As a courtesy, we will gladly submit your claims to your insurance. Please note that your insurance is a contract between you and your insurance carrier and our office is not a party to that contract. Benefits differ from one company to another, and not all services are covered benefits. Please contact your insurance directly if you have questions about your specific dental coverage.

We are a preferred provider with Delta Dental PPO and Premier Networks

All copayments and deductibles are due at the time of service. All charges not paid in full by the insurance company are your responsibility, regardless of reason for nonpayment. After dental insurance has paid its portion, a statement is sent to the mailing address on record for the remaining balance. Payment is expected within 30 days of the statement date, to avoid further fees. An account with an unpaid balance past 90 days will be sent to collections. For your convenience, we accept cash, check, MasterCard or Visa.

If you do not have dental insurance: The person who brings the child is considered the “guarantor” and the “responsible party.” The responsible party is expected to pay their full portion at the time of each visit. If you do not have the payment available on the date of service, we may suggest that you reschedule the service for a time that’s more convenient for you to pay. We are happy to discuss costs of services upon patient request. Returned personal checks: If the bank returns a check due to insufficient funds, the responsible party will be charged a $35 fee. All future payments must then be received in the form of cash or credit card. Missed appointments: Please call 24 hours in advance if you are not able to arrive for your schedule appointment. If 2 scheduled appointments are missed, there will be a $50 charge per child.

Patient Name _____

Responsible Party’s Name _____

Relationship to the Patient_____

Today’s Date _____

Signature _____

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Informed Consent

I hereby represent and warrant that I am the custodial parent and/or legal guardian for the indicated child. I hereby authorize to have my child treated for the necessary diagnostic (examination, x-rays), preventative services (cleanings, fluoride if indicated), restorative dentistry (filling and/or crowns) and/or emergency treatment that may be deemed necessary. Dr. Wagner will go over all findings with you and address any concerns you may have about your child or treatment options.

CONSENT & AUTHORIZATION: I authorize dental treatment on my child and hereby acknowledge that I have read and understand this agreement and consent form. I agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Wagner Pediatric Dentistry, LLC. Without any reservations, I agree to abide by the policies outlined herein.

If asked by the staff, I allow my child's picture to be used in marketing material, social media and/or printed materials.

Patient Name _____

Responsible Party's Name _____

Relationship to the Patient_____

Today's Date _____

Signature _____