WICHITA STATE UNIVERSITY

Advanced Education in General Dentistry Program (AEGD)

Patient Financial Information and Consent

As a patient serving clinic within an educational program, fees for dental services have been set and all payment is due at the time of services rendered.

We do **not** offer sliding scale fees or adjusted fees based on income. We are **not** a Medicaid or KanCare provider.

Please read, initial after each statement and sign at the bottom of the page:

1. Payment is due at time of services- Payment is due at the time of appointment. If a patient has insurance, the co-pay or out-of-pocket expense is due at time of service. ____

2. If a patient has dental Insurance- We are an in-network provider for the following insurance companies: Delta Dental, Blue Cross Blue Shield, Aetna, MetLife and Cigna. While we accept all private dental insurances, for those patients with out-of-network policies, payment is due in full at time of service. We will then file your claim and have your insurance company reimburse you. ____

3. Estimate of Payment- We provide a close estimate of patient out-of-pocket expenses. For any major dental service, we highly recommend a pre-determination be submitted to your insurance company. _____

4. Delinquent Accounts- If a patient elects not to pay a debt in full or set up a payment plan, the account will be turned over to collection agency, which will report your name to the credit bureau and supplementary communications may use pre-recorded voice or texting to cellular or or wireless devices. Collection fees may be charged to your account, up to 33%. **Please note: as an institution of the State of Kansas, your name may be submitted tothe Kansas Setoff Program, resulting in any debt owed to be collected from state income tax returns/refunds. ____**

5. Appointment Cancellations/Failure to Show- We require a 24 hour notice for cancellations or rescheduled appointments. Failure to show for an appointment or cancel with 24 hours may be subject to a $50 Cancellation Fee that must be paid before rescheduling. If calling after hours to cancel, please leave a voice message so it can be retrieved the following day.

Patient Signature: _____Date:_____
Print Name: _____
Parent or Legal Guardian: _____