BAYSHORE
DENTAL EXCELLENCE

7643 Market Street
Wilmington, NC 28411
(910) 686-9802

Drs. Todd Walls, Ashley Basinger, Alex Hicks, Michael Levine, and Wes Winslett welcome you to our practice! We are committed to providing you with the best possible dental care and we hope you come to enjoy your visits with us.

Our office hours: Mondays through Thursdays 7:00 a.m. to 7:00 p.m.
Fridays 7:00 a.m. to 1:00 p.m.
Saturdays 7:00 a.m. to 12:00 p.m.

Appointment reminders are sent in advance of your visit by phone, email, and/or text message. Twenty-four hour notice of cancellation is required, otherwise your appointment is considered broken. Two broken appointments may incur a $30.00 broken appointment fee; three broken appointments may result in dismissal from our practice. Please be courteous regarding this matter as we wish to develop a long-term relationship with you and your family. In fairness to all patients, please arrive on time for your appointments. Our office reserves the right to reschedule late arriving patients; conversely, we will do our best to notify you if we are delayed in any way.

Payment is due at the time of service for all visits. Our office will estimate treatment costs to the best of our ability; however, costs vary depending on your dental needs, changes in care and, if applicable, the terms of your specific dental benefit plan.

Insurance:

- When you have dental insurance, your co-insurance and any deductible is due at the time of service.
- Your insurance is a contract between you and your insurance provider.
- We are not party to that contract and cannot become involved in disputes between you and your insurance regarding coverage, deductibles, or terms of the plan.
- We encourage all insured patients to refer to your member information or plan administrator for full details of your coverage.
- Some insurance companies send payment directly to the patient. When you receive the check, we require payment within 30 days. Failure to pay in that time will require all future visits to paid in full at the time of service.
- **In the event insurance is denied, you are responsible for the entire bill.**

There is a $28.00 fee for any returned checks.

I have read the above policy and understand my responsibilities.

Signed _____ Date _____

We look forward to many years of caring for your smile!