**PAYMENT & CANCELLATION POLICY**

***Campbellsport Family Dentistry***

***130 N. Fond du Lac Ave.***

***Campbellsport, WI 53010***

***(920) 533-8512 PHONE***

***(262) 270-2505 FAX***

Dr. Kathrine Su and her team are committed to providing you with the best possible care. This information is designed to alleviate any questions regarding payments and to help guide you through the rapidly changing world of dental insurance plans. **Please read this information carefully.** Initial and Date where indicated on the page**, indicating your acceptance of our policies and procedures.**

**Optional Payment Terms for those with Insurance:**

1. **Major Service-Two payment option:** We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay half your co-pay at the first appointment with the second half due at the time of delivery for the crown/bridge or the final try-in for dentures.
2. **Credit Card, Checks, and Cash Payment Option:** We accept all major credit cards.
3. **Care Credit:** This healthcare credit program offers no interest for 6 months for charges of $200 or more. There is no down payment or membership fee. The application approval process can be completed in a few minutes in our office or online at [www.carecredit.com](http://www.carecredit.com).

If you have dental insurance, as a courtesy to you, we will submit your claim for payment by your insurance.

Your insurance is a contract between you, your employer and the insurance company. We are not included in that contract and therefore cannot change benefits you have. Not all services recommended for your dental health are covered in full or in part by your insurance. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary fee for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Your complete insurance information will be required at the time of service. You are responsible for informing us of any changes in coverage. We can make no guarantee to estimated coverage for payment. Be assured we will do everything possible for you to receive the full benefits of your policy. Insurance claims cannot be backdated.

**Optional Payment Terms for those without Insurance**:

1. **Credit Card Payments:** We charge a 3% service fee for using a credit card.
2. **Debt Card and Virtual Payments:** There is no service for these transactions.
3. **Care Credit:** This healthcare credit program offers no interest for 6 months for charges of $200 or more. There is no down payment or membership fee. The application approval process can be completed in a few minutes in our office or online at [www.carecredit.com](http://www.carecredit.com).

*Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Confirmation Policy:**

Campbellsport Family Dentistry requires confirmation no less than 24 hours prior to your appointment. If we are unable to contact you, we will not be able to hold your appointment and you will need to reschedule.

**Broken Appointments:**

**Late and Missed Appointment Policy**

At Campbellsport Family Dentistry, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved, especially for you with our providers.

If for any reason you must cancel or change your appointment, we ask that you give our office at least a 24-hour notice to offer that spot to someone else.

* **1st missed appointment**: If an appointment is missed or canceled within the 24-hour window, we will reach out to you by phone and letter to remind you of our policy and to reschedule your appointment.
* **2nd missed appointment**: After your second missed appointment, we will inform you by mail of the $25 less than 24-hour or no-show appointment fee.
* **3rd** **missed** **appointment**: If there is a third missed appointment, we will inform you by mail of the status change of your account. Going forward, for you to schedule a future appointment with us, a non-refundable deposit of $50 will be required.

Campbellsport Family Dentistry] is committed to safeguarding the privacy of our users. We want to assure you that we do not share your personal information with third parties. This privacy policy outlines how we collect, use, and protect the information you provide to us.

Information Collection:

We collect only the information necessary to provide and improve our services. This may include name, email address, etc. We do not sell, rent, or share this information with any third parties.

How We Use Your Information:

No personal information, mobile number, or messaging consent information will be shared with third parties or affiliates for marketing or promotional purposes.

Your Choices:

You have the right to access, correct, or delete your information. If you have any concerns or questions about your data, please contact us at [contact information or link].

Policy Changes:

We may update our privacy policy from time to time. Any changes will be communicated to you, and your continued use of our services implies your acceptance of the updated policy. By using our services, you agree to the terms outlined in this privacy policy.

Last updated: 10/8/2025

*By clicking 'Submit', you agree to Campbellsport Family Dentistry's Terms of Use and Privacy Policy. You consent to receive phone calls and SMS messages from Campbellsport Family Dentistry to provide updates and information in regards to your business with Campbellsport Family Dentistry. Message frequency may vary. Message & data rates may apply. Reply STOP to opt-out of further messaging. Reply HELP for more information. See our* [*Privacy Policy*](/new-patient-forms#4e65b608-6ff4-40a0-a831-0d99122824c9)*.*

**Social Media Release**

I agree to allow my dental office to respond to any Facebook or Google Review posts and acknowledge I am a patient of record.

*I agree:*  ***OR*** *No Thank You:*

**Text Messaging**

I agree to allow Campbellsport Family Dentistry to text me regarding my scheduled appointments

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with Patient: Self Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_