Skutak Dental, S.C.

700 Eagle Nest Boulevard
Suite E
Rothschild, WI 54474
715.355.4433

Insured and uninsured payment policy

Welcome to our office. It is our intention to make your visit as comfortable as possible. Please take the time to look over our office payment policy. If you have any questions please do not hesitate to ask any team member.

Please provide us with your dental insurance card. We will gladly process your claim, but we do request that you pay your estimated portion (deductible and/or copay) the day of treatment. Signing below authorizes Skutak Dental SC to bill your insurance carrier and apply the insurance payment to your outstanding account balance.

If you do not have dental insurance, payment in full is expected the day of treatment. We do offer Care Credit which is a monthly payment plan. We also accept check, cash, or Visa/MasterCard/Discover.

Any amount not covered or paid by your insurance carrier after 30 days is your responsibility.

Our office requires a minimum of 24 hour notice to cancel or reschedule appointments. Without a 24 hour notice, a fee will be implemented on your account and must be paid prior to scheduling any future appointments.

In signing below, I agree to assume full responsibility for payment of any treatment provided.

Responsible party: _____
(Please print your name)

_____ _____
(Signature) (Date)