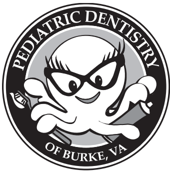

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Financial Policy, Office Policy, Dental Insurance Information

Dear Patient:

Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family will feel welcome to our dental family.

♦**Dental Insurance**-If you have dental insurance, as a service to you, we will complete your insurance form with all the necessary information and submit it to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, *you will be responsible* for paying the full balance amount left on the account at that time. I understand that the payment of my bill is my legal obligation. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining providers covered by my current insurance. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for eligibility, filing, follow-through, or confirmation. Notification of change of insurance carrier or level of coverage (e.g. PPO) is my responsibility, as is any change of address.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

♦**If your insurance company has not made a payment within 30 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship).**

♦**Payment is due at the time treatment is rendered.** We accept Cash, checks, Master Card, Visa, Amex or debit cards.

♦**Monthly payments-** If you need to make long-term payments we can offer financing with Care Credit. You must qualify to use this option. Or we can offer a two-month payment plan with a credit card on file.

All patients with an outstanding balance will receive a statement each month. There is a finance charge of 1.5 % (18% APR) on all accounts 60 days overdue. If you have a returned check you will be charged a return check fee of $50.00 per check.

We reserve the right to charge for appointments broken with out proper 48 hours notice. The length of the appointment scheduled will determine a charge for the broken appointment. There is a minimum charge of $35.00 for a broken appointment cancelled with less than 48 hours notice.

SIGNIFICANT EXPOSURE- Section 32.1-45,1(A) and (B), Code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and /or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles or non-covered services requested by me. **IN THE EVENT THAT THIS ACCOUNT SHOULD BECOME DELINQUENT AND IS THEREFORE PLACED IN THE HANDS OF AN ATTORNEY FOR COLLECTION, I AGREE TO PAY ATTORNEY FEES OF 33 AND 1/3% OF THE UNPAID BALANCE OWING, PLUS ALL COURT COSTS, AND INTEREST. INTEREST IS CHARGED AT A RATE OF 1.5% PER MONTH (18% APR), BEGINNING 30 DAYS AFTER THE MONIES HAVE BECOME DUE OR EXPENSES HAVE BEEN INCURRED. I FURTHER AGREE TO PAY RETURNED CHECK CHARGES OF $50.00 PER RETURNED CHECK AND $75 PER APPOINTMENT CANCELLED WITHOUT 24 HOURS NOTICE. ANY PROFESSIONAL/COURTESY DISCOUNT IS CONTINGENT UPON EXECUTION OF THE PAYMENT TERMS OUTLINED ABOVE AND MAY BE REVERSED AT THE DISCRETION OF THE PRACTICE IF THE ACCOUNT GOES INTO DEFAULT.**

This agreement is reaffirmed each time services are received by me or any person on my account, including, but not limited to, any child, stepchild, or parents within my family, who receives services from the above-named provider or any other provider within the practice.

In the event the account is turned over to collections you will need to discuss all payment arrangements with our attorney **Charles Anderson, Attorney at Law, 11860 Sunrise Valley Drive, Suite 100, Reston, VA 20191.**

______________________________________ ____________________

Signature of patient, parent or guardian **Date**