



Office, Insurance, and Financial Policies Information

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. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Patient Registration form before seeing the doctor.

PAYMENT IN FULL IS DUE AT TIME OF SERVICE
WE OFFER AND EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL

◆REGARDING INSURANCE:

We may accept assignment of insurance benefits after you furnish us with your full insurance information and we are able to reach your insurance carrier to verify that information. However, we do require that you pay your deductible and any patient portion at the time of service. If your insurance company has not made a payment within 45 days of billing, the balance will become your responsibility.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY
WE ARE NOT A PARTY TO THAT CONTRACT

Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

◆"USUAL AND CUSTOMARY RATES":

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

◆MINOR PATIENTS:

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/Discover, or payments by cash or check at the time of service has been verified.

◆MISSED APPOINTMENTS:

We reserve the right to charge for appointments broken without the proper 24 hour notice. Please help us serve you better by keeping scheduled appointments.

◆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 release in accordance with the applicable laws and the policy of the local hospital.

I have read and understood fully the financial options. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs and any other charges incurred to collect this account. I also hereby agree to waive the "Homestead Exemption".

***Please let us know if you have any question or concerns regarding our Financial Policy.

I have read the Financial Policy. I understand and agree to this Financial Policy. I authorize and release information and payment of my dental insurance to the dentist.

X _____ Date _____
Signature of Patient (or Responsible Party)