Our Mutual Financial Agreement

Patient : last name : _____ first name : _____ mid name : _____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of Our Mutual Financial Agreement which we require that you read, agree to, and sign prior to any treatment.

All patient must complete our Patient Information Form before seeing the doctor.

We accept cash, checks, VISA, MasterCard, Discover, and American Express. We do offer an extended payment plan with prior credit approval.

FULL PAYMENT IS DUE AT TIME OF SERVICE **RETURNED CHECK FEE IS $35.00**

A credit report may be obtained. In the event payment is not received within thirty (30) days of its due date, then i agree to pay a 1 1/2 % per month service charge (18% APR) on the overdue balance until paid. In the event that my account is referred to an attorney for collection, then I agree to pay attorney's fees in the amount 33 1/3 % of the overdue balance and I further agree to pay all court costs incurred in the collection of the overdue balance.

Regarding Insurance

Dental insurance is great! We gladly help fill out those complicated forms for you and even accept the assignment of insurance benefits so that your "out of pocket" can be minimized. We will even allow our office insurance "expert" to evaluate your particular insurance plan and work to get you the maximum reimbursement - all just for you! (Please bring all your insurance information or insurance booklet with you to help us out.) We cannot bill your insurance unless you bring all insurance information and an original claim form. Should you hava any change in your insurance information please inform the practice in writing. You should remember that your insurance policy is a contract between you and your insurance company and we are not a party to that constract. What that means is our doctors work for you and get paid by you; i.e., you are ultimately responsible for the payment of fees for our service.

Concerning Insurance Co-Payments : You will need to pay any deductible and fee co-payment the day of your appointment with cash, check, credit card, or pre-approved extended payment plan. If your insurance company has denied or not paid your account in full in 75 days, the balance of your account will then become your responsibility to pay within 15 days. Please be aware some and perhaps all of the services provided may be "non-covered" service and not considered so-called reasonable and necessary under your insurance program.

*Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minors

The adult accompanying a minor and the parents or guardians are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

UCR (Usual and Customary Rates)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our level of care. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates.

Missed Appointments

Unless canceled at least 48 hours in advance, our policy is to charge for missed appointmnets at the rate of a normal office visit, which starts at the rate of $72.00. Please help us serve you better by keeping scheduled appointments.

Patient Records

In accordance with the appropriate Virginia Dental and other regulations and laws, original patient records must be retained at the paractice. In the event you ever request duplicate records including xu rays, models, casts, etc. There is a duplication fee for this process. The fee will be based upon the quantity of records/xu rays that are being released. This fee is minimum of $27.00. This fee will not be charged if we are referring you to another practice.

☐ I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless prhibited by law, or the treatig dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

_____ MM / DD / YYYY

Patient or Responsible Party Date

_____ MM DD YYYY

Financial Coordinator Date