



Financial Policy

Our office is committed to providing you with the highest quality dental treatment and the best possible care. We are happy to discuss our professional services and related fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. We encourage you to ask questions regarding fees, the office financial policy and your account status. You are responsible for all fees related to your treatment.

You are responsible for the timely payment of your account. We expect either payment in full or your co-payment on the day of service. We will file your insurance as a courtesy to you. If your insurance company has not paid your claim within 45 days you will be notified. You will be expected to pay your balance at that time. If the balance on your account is not paid in full within 60 days, your account will be forwarded to our collection service. Collection fees, court cost, attorney fees and any other fees would be your responsibility. In cases of disputes, you agree that venue and jurisdiction for all matters concerning our relationship shall be proper only in the courts of the City of Virginia Beach, Virginia. If you cancel your reserved appointment within less than 24 hours notice, or fail to come to your appointment, a charge will be incurred.

Insurance

This office is a participating provider in most (but not all) major insurance plans. We will be happy to help you maximize your dental benefit. It is very important that you understand your insurance benefit is a contract between **YOU** and **YOUR** insurance company. We will gladly file your claim as a courtesy to you. However, you are ultimately responsible for any and all fees related to your dental treatment. Any grievances or concerns regarding coverage and benefits should be directed to your employer or insurance provider of your dental coverage. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and benefits other than to supply factual information. In cases where a secondary insurance is involved, you will be required to pay the portion of your account balance that was not covered by your primary insurance. We can not accept secondary insurance payments due to the extraordinarily long delay in payments while primary and secondary insurance companies debate their individual responsibilities.

This office does not participate in HMO's or DMO's. It is imperative that you discuss your co-payment obligation prior to treatment. Due to the significant discount from our normal fee with certain insurance companies, your account must be paid in full on the date of service, per your insurance contract.

I have read the above financial policy and understand the provisions of the agreement. I have had an opportunity to ask questions and have them answered to my satisfaction. By signing this agreement, I accept the terms, provisions and obligations of the financial policy of this office.

Note: All account balances over 30 days are subject to a 1.5% finance charge monthly, 18% APR. In the case of default on payment of this account, I agree to pay collection costs and attorney fees of 33 1/3% incurred in attempting to collect on this outstanding account balance.

Signature of patient/responsible party: _____ Date: _____