FINANCIAL POLICY

EFFECTIVE JUNE 12, 2007

FEES AND PAYMENTS

PAYMENT FOR SERVICES MUST BE MADE BY ONE THE FOLLOWING OPTIONS:

PER APPOINTMENT- IF YOU ARE NOT COVERED BY AN INSURANCE PLAN, FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, Check, Visa, MasterCard, Discover and American Express. Please note there will be a fee of $30.00 for returned checks.

CO-PAYMENT- We will estimate your co-payment based on the most current information provided by your insurance carrier. CO-PAYMENT IS DUE AT THE TIME OF YOUR VISIT.

You must understand that YOUR DENTAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER, AND NOT BETWEEN THE INSURANCE CARRIER AND THE DOCTOR.YOU ARE FULLY RESPONSIBLE FOR ALL DENTAL FEES EVEN IF YOUR CARRIER DENIES OR EXCLUDES COVERAGE. We are only able to estimate your benefits and it is not a guarantee of payment.

In the effort to hold costs down, payment is due when services are rendered. For services exceeding **$1,000**, you may apply for a payment plan through care credit which must be arranged and approved in advance of your appointment.

Lab related services such as crown and bridge, partial and full dentures require 50% at the preparation date and 50% at the completion date. If you have insurance benefits on these services, you must pay half of your portion at the start date and the remaining half when the service is completed. Payment plans may be arranged through our office or **Care Credit** if the amount exceeds **$1,000**.

INSURANCE ARRANGEMENT

As a courtesy to our patients who have dental insurance coverage, we will be happy to file your claim electronically. Your deductible and co-payment is due the day of your service. We will figure these amounts for you using the information provided by your plan. An amount exceeding your annual maximum is due when your service is rendered. In the event the insurance claim is not processed in a timely manner, we will file the claim a second time. However, further delays caused by the insurance company will require you to make full payment to our office. To expedite processing, you will need to contact the insurance company directly.

Claims to secondary insurance carriers are also filed for patients as an office courtesy; however, we do not accept payment assignment. The remaining balance after the primary carrier's payment is the patient's responsibility. The secondary carrier will submit the benefit payment directly to you.

CANCELLATION AND MISSED APPOINTMENT CHARGES

Broken appointments are not fair to any of the parties involved. They deny other patients the use of this time, they cost the practice money as the staff salaries and other expenses continue. They make our office hesitant to appoint that patient again. Our practice does not profit from these charges. We merely cover expenses for our time that was set aside for you.

In order to recoup and recover expenses incurred by broken appointments we charge $60.00 per hour. These charges are assessed to patients that have not given our office 48 "business day" hours notice.

INTEREST, LATE CHARGES & NONE-PAYMENT

INTEREST: Interest will be charged at a rate of 1.5% per month on the current amount due. Interest is not charged on amounts due from your insurance carrier.

LATE CHARGES: When current patient balance is due, is not paid by the due date, late fees and interest are added to the account.

NONE-PAYMENT: This office reserves the right to place any delinquent account with a collection agency. You agree to pay any and all fees and/or court cost if necessary. Please be aware that your account with our office is not a revolving credit line. We assist with insurance as a courtesy only. All fees are due payable upon demand. In the event of any and all disputes with the insurance carrier fees must be paid to the office. You are responsible for disputing insurance company liability directly with your carrier. Our office will provide documentation only. In the event the insurance company wants documentation beyond codes provided by the American Dental Association terminology, additional documentation fees may be charged.

TRANSFER OF PATIENT RECORDS

Your request to transfer your dental records should be submitted in writing. We will copy your current x-rays and mail them certified to a dentist of your choice. The fee is $25.00 per family. If you have any questions please ask our Office Manager for assistance.

By your signature it is understood that you are directly responsible for payment for the services rendered whether or not your insurance is involved. If it becomes necessary to go outside the office to any agency for the collection of fees, you will be charged for the additional expenses.

Patient or Guarantor _____

Date _____

Virginia State Testing Law

Pursuant to Virginia Law 32.1-45.1- Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C, is deemed to have consented to HIV, Hepatitis B or C testing and disclosure of the result to the person exposed this deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

Print patient's name: _____

Signature: _____

I HAVE READ AND ACKNOWLEDGE THE HIPPA PRIVACY PRACTICE STATEMENTS.

Signature _____