

Office Dental Insurance Information and Financial Policies

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 you and your family will feel welcome in our practice and have the ultimate experience in dentistry each visit.

Since we know it is not always possible to pay your for the investment of your dental care, we would like to explain our financial options. Please let us know what option(s) may work best for you.

- **Dental Insurance** – If you have dental insurance, we will submit claims to the insurance company with all the necessary information and x-rays as a service to you. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship. Therefore, the patient is responsible for paying their percentage of the visit at the time services are provided.
- **2 Equal Payments** – This payment option is available for patients who have established a payment history for a period of one year. This option is not available to patients who have had delinquent accounts or have a history of not showing up for confirmed/scheduled appointments during their time as a patient.
- **Monthly payment options** – All patients may apply for long-term payment plans that we offer through a partnership with Care Credit or Chase. You must qualify for these options.

We reserve the right to charge for missed, broken, or rescheduled appointments without the proper advance notification (**2 business days**).

SIGNIFICANT EXPOSURE – section 32.1-45,1 (A) and (B), Code of Virginia (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 the local hospital.

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

I have read and fully understand the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles, or non-covered services requested. 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, interest, and any other charges incurred to collect on my account.

Signature of patient or guardian

Date

Insurance Information

Name of Insured: _____ Is the insured a patient? Yes No

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____
Street Address City State Zip

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Telephone: _____

Assignment of Benefits

I authorize the release of any dental information necessary to process claims and payment of dental benefits to the named provider for professional services rendered.

Name _____ Date _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content

Signature of patient, parent, or guardian Date _____ Relationship to Patient _____