4300 Plank Road, Suite 230 * Fredericksburg, VA 22407 * 540-785-5300

Office Policy & Patient financial responsibilities

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Office Policies which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

- I authorize the dentists and staff at this dental office to provide any and all forms of treatment and medication that may be necessary or advisable in connection with my (or my dependent's) dental care. I further consent to the dentists and staff choosing and employing such methods and means as is deemed fit. I understand that prior to treatment, an explanation of the procedure(s) involved will be given to me, and I agree to ask any questions that I may have, and to raise any issues, prior to the start of the treatment. Also, I understand that there are rare but real risks associated with local anesthesia as permanent or temporary paresthesia. I understand those risks and will ask any questions that I may have prior to treatment, and consent to local anesthesia being administered as part of my dental treatment if required.
- I understand that pursuant to Virginia Code 32.1-45.1, any patient who exposes a health care provider (or employee) to bodily fluid in a manner which may transmit the Human Immunodeficiency Virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing, and disclosure of the results to the person exposed. Conversely, this deemed consent also applies to a health care provider (or employee) who exposes a patient to bodily fluid in the same manner. I understand that the results of this test are confidential and will only be released to: medical personnel directly responsible for my care and treatment, the exposed party, and the health care provider responsible for the exposed staff member to ensure appropriate medical evaluation and care. In the case the above stated condition occurs, I agree to comply fully and immediately with the above referenced Code.
- I authorize the dentists and staff to take photographs, study models, and/or radiographs of my face, jaws, and teeth. I understand that these photographs, study models, and/or radiographs will be used as a record of my care and treatment, and further authorize their use for education or teaching purposes by this office and to any other dentist I may be referred to for consultation or treatment.
- I understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% per month (18% annually). I further agree that where collection activities are employed, whether via collection agencies or legal proceedings, in order to collect any delinquent amounts owed by me, I shall be responsible for all costs of collection, including but not limited to, court costs, interest, and attorney fees in the amount of 33 and 1/3% of the total principal and interest owing on my account, whether or not formal litigation is instituted.

Regarding Payment

- Notify us of any changes in your address or insurance information at the time of the change.
- Please fill out our registration, insurance and medical history forms completely and as thorough as possible. Unfortunately, we cannot see you without these being completed. Due to HIPAA Privacy Laws, we require your social security number and the subscriber's.
- If you are more than 15 minutes late for an appointment, you may be asked to reschedule.
- We accept the following forms of payment: Cash, Check, Visa and MasterCard.
- Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing manager.

- If necessary, I agree to cancel or reschedule any appointment at least two business days prior to my appointment time in order to avoid a potential $50 non-refundable cancellation fee. I also agree that being substantially late for an appointment or missing an appointment altogether, shall be deemed a cancellation and that the cancellation fee may apply.
- If dentures, partial dentures, crowns and bridges, or mouthguards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.
- The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.
- Checks that are returned to our office from your financial institution, as well as a declined credit card payment, are subject to a $50.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

- Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed, however, it is also your responsibility to check with your insurance company to verify that we are a participating provider of your health plan prior to services.
  - All insurance co-pays and deductibles must be paid at the time of service.
  - If you do not have a valid insurance card (enrollment information will not be acceptable), you will be required to pay in full at the time of service. You will then be responsible for filing a claim with your insurance company for reimbursement, or you will have to reschedule your appointment.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I, _____(print name) have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice. I certify that the information I have provided, especially regarding my medical history, is accurate, and that I understand that incorrect or incomplete information being provided may be dangerous to my health. I also agree to abide by the office's policies, including its payment and financial policies. Furthermore, I have reviewed and accept the offices "Notice of Privacy Practices (HIPAA) that is available to me upon request.

Signature of Patient (or Responsible Party):_____

Date:_____