Lonny D. Grimmer, DDS and David Q. Le, DDS, PC
Ashbrook Center for Dentistry
44345 Premier Plaza, Suite 230
Ashburn, Virginia 20147

PATIENT'S FINANCIAL RESPONSIBILITIES

Thank you for choosing the Ashbrook Center for Dentistry as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the dentist.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECK OR VISA/MASTERCARD/DISCOVER AND AMERICAN EXPRESS

Insurance Assignments
If our office is able to accept your insurance company's assignment, it does not absolve you of full responsibility for the charges for the treatment rendered. We will estimate your co-payment of the treatment fee that may not be paid for by your current insurance plan. The co-payment estimate provided by this office is considered as a guideline until the final insurance payment is received and your account has been reconciled. Our office makes no guarantee of the co-payment estimate, and you are responsible for all treatment fees in their entirety. As a service to our patients, claims are submitted promptly to your primary insurance company after treatment is rendered. If the claim is not paid by your insurance company by the 61st day after treatment, the entire balance will be billed in full to you.

Our administrative staff prides itself on helping patients maximize their insurance benefits. We are always available to answer your questions.

Usual and Customary Rates
Our office is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. We use only the most advanced techniques, materials and labs because we believe you deserve only the very best. Therefore, our fees are not based upon any insurance company's fee schedule, and our fees are often above the benefit allowances provided by most insurance plans. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates.

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

Minor Patients
The parent/guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or American Express, or payment by cash or check at the time of service has been verified.

Cancellation Policy
If you are unable to keep your appointment, we kindly ask that you provide us with at least 24 hours notice. This courtesy on your part will make it possible for us to give your scheduled appointment time to another patient. We reserve the right to bill the patient for late cancellations or no-shows.

Service Charges
Be advised the policy of this office is to apply the interest of 10% per month to all accounts over 60 days, regardless of the insurance involvement. Any balances that are uncollected after 60 days will be subject to a late fee of $50.00.

There will be a $35.00 handling fee for any RETURNED CHECKS.

Collection Fees
We will refer all delinquent accounts to a collections agency and report these accounts to the Credit Bureau. Collection fees will be charged to any delinquent accounts. These fees will include all attorney fees, all court costs and courier/mailing fees associated with our efforts to resolve the delinquent account.

A submission to treatment implies consent as outlined in this service agreement.

Patient's Name: _____
Please Print Name

Signature of Patient/Responsible Party: _____

Date: _____