Office and Financial Policies

PLEASE INITIAL EACH STATEMENT BELOW AND SIGN THE ACKNOWLEDGEMENT OF POLICIES:

PAYMENT

X _____ **Full payment is expected at the time of service**, unless arrangements are made prior to treatment. Financing is available through Care Credit. If you choose to finance treatment through Care Credit, arrangements must be finalized before the first treatment appointment.

MISSED APPOINTMENTS

X_____ There is no charge for rescheduling an appointment provided 24 hours notice is given. Otherwise, a minimum charge of $20.00 per half hour missed can be incurred. Once an appointment has been made, please remember that this time has been reserved specifically for you. We thank you in advance for honoring your scheduled appointments.

PAST DUE ACCOUNTS

X_____ **Accounts sent to COLLECTIONS can be charged an additional 33-40% of the remaining balance due to cover the COLLECTION FEES.** If your account is turned over to a collection agency, the fact that you received treatment at our office may become a matter of public record. There will also be a $35 handling fee for any returned checks.

INSURANCE ACCEPTANCE

X_____ **Please remember that your policy is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. You are ultimately responsible for your bill, and you will be required to pay for any services not paid for by your insurance.**

X_____ **Because all insurance policies vary, there may be a portion of your bill that insurance will not cover. Please understand that you will be required to pay for the difference or co-pay on the day of service.** If you have a deductible on your dental policy, you may have to pay the deductible in addition to your co-pay. **Any estimate provided by this office should be considered only as a guideline until the final insurance payment is received. We can make no guarantee of the insurance payment as estimated.** We submit claims as a courtesy to our patients, and they will be submitted promptly after treatment is rendered.

DIVORCE
X_____ In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

INSURANCE REIMBURSEMENT ON FILLINGS
X_____ This office uses Resin (tooth colored) and Amalgam (silver) fillings. Some insurance companies will reimburse for Amalgam fillings on posterior (back) teeth even if a Resin was done. The patient/responsible party may be asked to pay the difference at the time of service. If there are any questions please ask the front desk staff.

BLOOD BORNE AND INFECTIOUS DISEASE
X_____ By the nature of our profession, the dentist, hygienists, and assistants are routinely exposed to blood and body fluids during the treatment of patients. In accordance with Section 32.1 - 45.1 of the Code of Virginia, Tidewater Family Dentistry requires that if an employee is exposed to body fluids in a manner that may transmit blood borne or infectious disease, both the employee and the patient will be tested for disease. By initialing this section and signing this form you authorize the release of your lab results to Tidewater Family Dentistry for our records.

ACKNOWLEDGEMENT OF POLICIES

I agree to be fully responsible for my account. I will pay for services as they are rendered, unless prior arrangements are made. I have read, understand, and agree to the above policies.

X Patient's Signature

_____

Patient's Name Printed

_____

Date _____