FINANCIAL POLICY

1. Charges for services rendered are due and payable the day of the appointment.

2. **We will assist with filing insurance; however, the Patient, Parent, or Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company**. There are no exceptions. When treatment *co-pays* are quoted by the office, these are **estimates** only, your actual insurance coverage may be less or more.

3. Personal checks that are returned due to "insufficient funds" are subject to a $30 service fee.

4. Appointment cancellations with less that 48 hour's notice are subject to a fee of $35.00 per 30 minutes for each appointment scheduled for less than 2 hours, and $200 for appointments scheduled for two (2) hours or longer.

5. All accounts over 60 days will be considered past due. Such accounts are subject to 18% APR or 1.5% monthly finance charges. Past due accounts may be referred to an authorized collection agency. Accounts sent to a collection agency will be assessed a $30 collection fee or 33 1/3% collection charge on the unpaid balance, whichever is greater. The Patient, Parent, or Guardian will also be liable for any applicable attorney fees and court costs. Accounts that have been referred to an outside collection agency will be placed on a CASH ONLY basis for any future treatment.

6. We are required by the State of Virginia to keep patient records for three years past the final date of treatment. Records of patients that have not been to this office in over three years may be purged. If you are moving or leaving the practice for any reason you may want to request a copy of your records. There may be a minimal charge to copy your x-rays and records.

7. Payment plans are available only for orthodontic treatment.

8. Amalgams (silver fillings) are no longer used at this office. Most insurance companies do not pay full benefits due to exclusions in individual policies for composite (tooth colored) fillings. The patient, parent or guardian is liable for all additional costs.

I have read and understand the Financial Policy of Smiles at Reston Town Center. I agree to be responsible for all dental services and materials not paid by my dental insurance for me or my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to Smiles at Reston Town Center, unless payable to me directly per the Insurance Plan.

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Signature of Patient/Parent/Guardian if Minor Date

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Print Name