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Office and Financial Policy

Full payment is expected at the time of service unless prior arrangements have been made.

INSURANCE ACCEPTANCE

Please remember that your insurance policy is a contract between you and your insurance company. It is ultimately the patient's responsibility to know and understand their dental benefits. 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 by your insurance.

We submit claims as a courtesy to our patients, and will do so promptly after treatment is rendered. Because all insurance policies vary, there may be a portion of your visit that insurance will not cover. Please understand that you will be required to pay for the difference or co-pay the day of your service. We provide an **estimate** of insurance coverage that is to be considered a guideline until final payment from your insurance company is received. We can make no guarantee that the insurance payment will match the estimate. We are participating providers with several insurance companies, you may check with our front office staff to see if we participate with your insurance. If you have a deductible on your dental policy, you must pay the deductibles on services it applies to, in addition to your portion not paid by insurance. If claims are not paid by the patient's insurance company by the 61st day after treatment it will be billed in full to the patient, and payment due immediately by the patient/responsible party.

MISSED APPOINTMENTS

Please remember that when an appointment is scheduled this time has been specifically reserved for you. There is no charge to reschedule an appointment provided that **48 hours notice** is given. A broken appointment fee of **\$20.00 per half hour** of reserved time may be incurred if proper notice is not given.

Thursday (3pm and later) & Saturday Appointments: These appointments are in high demand. Therefore, we require **48 hours notice** to reschedule or cancel an appointment. If for some reason you are unable to keep your appointment, you will be charged a \$20 broken appointment fee per half hour of scheduled time, and you will not be permitted to schedule Thursday evening or Saturday appointments again.

RETURNED CHECKS

There will be a **\$25.00** handling fee applied to your balance for any checks returned by the bank. Our bank will make three attempts to draw the returned balance. You may also incur a separate

\$50.00 handling fee from our bank for insufficient funds which would be added to your insufficient fund balance.

PAST DUE ACCOUNTS

Be advised the policy of this office is that interest of 1.5% per month (18% Annual Percentage Rate) will be applied to all accounts over 60 days past due, regardless of the insurance involvement. Any delinquent accounts will be referred to Court for legal action. There will be a collection fee of 33.3%, and/or court cost and reasonable legal fees should this be required. You understand if this account is submitted to an attorney, collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, that the fact that you received treatment at our office may become a matter of public record.

DIVORCE

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 the 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

This office uses only resin (tooth colored) fillings and not amalgam (metal) fillings. Some insurance companies will reimburse for amalgam filling price if a resin filling was done. We will bill you for the difference of the resin filling after the insurance payment has been received. If you have any questions about this please ask one of our staff or the doctor.

POLICY ON BLOOD BORNE AND INFECTIOUS DISEASE

By the nature of our profession, dentists, hygienists, and assistants are routinely exposed to blood and bodily fluids during the treatment of patients. In accordance with Section 32.1-45.1 of the Code of Virginia, we require that if an employee is exposed to blood or bodily fluids in a manner that may transmit blood borne or infectious disease, both the employee and the patient will be tested for disease.

FINANCIAL/OFFICE CONSENT

I agree to be fully responsible for my account. I will pay for services as they are rendered. I have read and understand that by signing this form I am agreeing to the terms and agreements listed.

Patient's/Guardian's Signature

Date

NOTICE OF PRIVACY PRACTICES

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. You may obtain a copy of the Notice of Privacy Practices at any time by contacting our office. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, containing all changes. Those changes may apply to any of your protected health information that we maintain.

I have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient's/Guardian's Signature Date

Guardians name and relation to patient: _____

Revocation of Consent: I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my consent will not affect any action taken in reliance on my consent before receipt of this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my consent.

Patient's/Guardian's Signature Date