**Financial and Appointment Policy**

Welcome to our practice. This information is provided to aid our patients in understanding our office policies. Please ask a staff member if you have any additional questions

**Financial Responsibility**

All treatment plan costs presented are ESTIMATES only. Fees charged for services rendered are the usual and customary fees charged to all our patients. Your individual policy may base its alloances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available by employer. Also, some companies take care of claims promptly while others delay payment for several months.

Dental Health Center of Northern Virginia takes pride in offering the best customer service available, and will gladly submit my insurance claims on my behalf. It is common that even with required dental treatment insurance companies can deny claims. Dental Health Center of Northern Virginia will appeal any denials in order to obtain the maximum reimbursement allowed by my insurance. I understand and agree that, if for any reason, an insurance company fails to pay for treatment; I will be responsible to pay the balance regardless of estimate insurance benefits.

**Payment Options**

Cash or Check, There is a $50 fee for returned checks.

Major Credit Cards: MasterCard/Visa/Discover/American Express

Care Credit or Lending Club

**Appointment Policy**

Dental Health Center of Northern Virginia requests 48 hours notice prior to any appointment changes. My appointment time is specifically reserved for me and failure to make my appointment on time without considerate notice prevents other patients, who need appointments, from being cared for. Dental Health Center of Northern Virginia makes every effort to see patients on time and end appointments on time. If I arrive late to an appointment I understand that the schedule may require my appointment be postponed or shortened.

I understand that it is my responsibility to inform Dental Health Center of Northern Virginia of any changes to my insurance or medical history prior to my appointment. If new insurance information is needed I will arrive 15 minutes early to my scheduled appointment or provide the information in advance.

**Patient Signature or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**