



FINANCIAL POLICY

Thank you for choosing Expressions Dental Care as your dental care provider. Our office is committed to providing you with the highest quality dental care. Please understand that payment of your bill is considered as 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. We do provide several payment options to accommodate our patient's needs. ***Please discuss your options with our staff to find the solution that is best for you.***

- Charges for services are due and payable the day of the appointment; Patient Copay
- 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. There are no guarantees of payment by insurance when services are rendered.
- Personal checks that are returned due to insufficient funds are subject to a \$30.00 service fee
- Appointment cancellations with less than 48 (business) hours notice are subject to a fee of \$60.00 for each appointment scheduled for less than 90 minutes and \$200.00 fee for appointments scheduled for 90 minutes or longer that are missed.
- ***Appointments 90 minutes or longer: We require the patient portion to reserve the time***
- All unpaid 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 \$30.00 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.
- 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.
- Payment plans are available only for orthodontic treatment, and must be made PRIOR to starting treatment.
- 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 Expressions Dental Care. I understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. I authorize and request my insurance company to pay directly to Expressions Dental Care any insurance benefits otherwise payable to me. I Understand that my dental insurance carrier may pay less than the actual bill for services and Expressions Dental Care completes and files my insurance claims as a courtesy. I understand that I am responsible for any unpaid or denied claims.

Thank you for understanding that as your dental care provider, our relationship is with you and not your insurance company. 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 Expressions Dental Care, unless payable to me directly per the insurance plan.

Please Print Name of Patient, Guardian, or Responsible Party

Date

Signature of Patient, Guardian, or Responsible Party