FINANCIAL POLICY

Sandra Daniels D.D.S.
3801 North Fairfax Dr Ste 25
Arlington Va. 22203

Our commitment is to provide quality dental care to the entire family though exceptional service and the utilization of advance technology.

Methods of payment

1. Cash, Check, or Credit card (Visa, MasterCard)
2. Dental insurance (described below)

Payment is required when services are rendered unless prior financial have been made.

Dental insurance (where applicable)

1. We are please you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits. We ask that your estimated co-payment and deductible be paid at the time of service.
3. Not all services are covered benefit in all contracts.

Related information

1. For return checks, a charge of $25.00 will be applied and balances older than 60 days may be subject to additional interest charges.
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for the collection of your bill (i.e., attorney fees, court fees, and collection agency fees)
3. We reserve the right to charge $25.00 for appointments canceled or broken without 48 hours of notice. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment has been made please remember that this time has been reserved exclusively for you.

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered. I agree to be responsible for any charges not paid by my dental plan. I understand that should my account be placed with an agency or attorney for collections, then I agree to be responsible for all cost incurred in the collection of my account, including attorney's fees, interest at 1.5% per month (18% per annum), and all court cost.

Patient name (Please Print): _____

Signature of patient or responsible party:_____

Date: / /