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***Office, Financial Policies and Dental Insurance Information***

**Dear Patient:**

Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental Insurance, schedule changes, etc. We always strive to maintain quality dentistry with our compassion in a comfortable and friendly atmosphere. We would like to welcome you and your family to our dental family.

**Since we know it is not always possible to pay your dental bill in full, we would like to explain the options that might work best for you.**

**Dental Insurance** - If you have dental insurance, as a service to you we will file your claim to your insurance company for you. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointment, we will ask that you pay the bill in full. We can provide you with any paperwork that you may need to be reimbursed from your insurance company. **Our office does not guarantee that your** i**nsurance company will pay for the treatment that you receive from our practice. If your claim is denied or the treatment is (down-coded) an alternate benefit is given, you will be responsible for the full balance left on your account at that time. X\_\_\_\_\_\_\_\_\_ (Initial)**

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documents that your insurance company may request to settle your claim. If your insurance company has not made payment on your claim within 45 days of billing, the balance will become your responsibility. **(Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.)**

**Payment Options -**  **Payment is due at the time of service.** If we are Filing a claim with your insurance company, we will collect your co-payment that may be due at this time. We accept **Cash, Personal checks, Master Card, Visa, American Express, Discover, Bank Debit Cards and Care Credit.** We do not provide any payment plans in our office.

All patients with an outstanding balance will receive a statement each month. There is a finance charge of 1.5% on all accounts that are 60 days past due. If you have a returned check there will be a returned check fee of $50.00 per check.

**Please let our office know as soon as possible if you cannot make it to your appointment.**

We reserve the right to charge for appointments missed without 48hour notice. The charge for a missed appointment is $50.00 per hour.

**Significant Exposure** – Code of Virginia Title 32.1 – 45.1 provides that in an event of significant exposure to bodily fluids, in any manner shall be deemed to have consented to testing for Human Immunodeficiency Virus (HIV), Hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the person who was exposed. Test results are confidential in accordance to HIPAA and all other applicable laws.

**Minor Patients** – All minor patients should be accompanied by a legal guardian, or have pre-authorized said child to be treated by the dentist/hygienist prior to arrival. All co-payments for treatment will need to be pre-paid prior to arrival or paid by phone at the time of services.

**I authorize and release my information and any payments of my dental insurance to Progressive Dental of Mechanicsville, Tyler Ball DDS**

I have read and understand all the above. I agree to accept responsibility for payment I may owe on my bill this includes but not limited to insurance co-payments, deductibles or any non-covered services. I understand that I will be billed for all outstanding balances, and in the event that my account becomes delinquent I will be responsible for any collections by our attorney with a fee of 33 1/3 5, court costs, interest, on the principal balance of 18% from the date of service, as well as any other charges that may occur to collect this balance. In the event the account is turned over to collections you will need to discuss any arrangements with our attorney.

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Patient Signature Date

If signing for a minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Minors name)