Financial Agreement and Office Policies

3505 Boulevard
Colonial Heights, VA 23834
Ph 804-520-5009
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Payment: Payment is due in full for each appointment as services are rendered. The payment options are:

- Cash
- Credit Card (MasterCard, Visa, American Express, Discover)
- Cashier's Check, from a recognized financial institution in the community. Acceptance of a cashier's check is at the sole discretion of the practice owner.
- **We do not accept personal checks.**

In instances where the service to be provided is above $500, the patient will be asked to pay a non-refundable deposit to secure an appointment slot. A deposit in the amount of 50% of the expected procedural cost is required. If the patient does not cancel the appointment within 36 hours, the patient will lose their deposit.

Dental Insurance: Dental **i**nsurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied", or "over UCR". We will file your primary dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusion, and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when it is requested by you.

Missed Appointments: A missed appointment is defined as a cancellation, no-show, or reschedule of an appointment with less than 24 hours notice. Our office requires 24 hours notification if you are unable to keep your scheduled appointment. If less than 24 hours notice is given a $25 fee will be charged to your account. Patients with three missed appointments will be asked to transfer their records to another practice. If a sedation or general anesthesia appointment is missed, the patient will be inactivated and dismissed from the practice. If any first time appointment is missed, the patient will not be seen by the practice for future appointments.

Emergency/After Hours Appointment: If you or your child is seen for an emergency visit after our regular business hours, an "after hours" fee of $150 is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

Late Arrivals: We ask that you arrive 15 minutes prior to your scheduled appointment. If you arrive 15 minutes past your scheduled appointment time, you will be asked to reschedule. A no-show appointment fee will apply.

Emergency Patients: New patients requiring emergency services will be required to pay $150 in cash or credit prior to being seen. This is a deposit for services rendered.

Duplication of Records: We charge a $15 fee to duplicate radiographs. The fee to copy an entire chart (records and radiographs) is $25. If the copies are lost, the patient is expected to pay another fee.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, collections charge, if any and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

Past Due Accounts: If your account becomes past due, we will the take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections cost which are incurred.

Collections Charge: Your account will be transferred to a collections agency once it is 60 days past due. The fee added to these accounts is 33 1/3%. In addition, all past due accounts will be assessed an interest rate of 18%. Please pay all bills accrued within a timely fashion.

Divorce: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Southside Family and Cosmetic Dentistry, P.C. and the Patient/Debtor named on this form. In this agreement the words “you”, “ your”, and “yours” means the Patient/Debtor. The word “account” means the account that has been established in your name for you or your child to which charges are made and payments are credited. The words “we,” “us”, and “our” refer to Southside Family and Cosmetic Dentistry, P.C.

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Patient’s Name

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Parent/Legal Guardian/Responsible Party (printed)

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Parent/Legal Guardian/Responsible Party (signature)