FINANCIAL POLICY

Patient First Name *

Patient Last Name *

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent your benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance affordable.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment.

Missed Appointments

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as for other patients. If you find that you must change your appointment, we require a minimum of 48 hour notice, so that we can make every effort to accommodate other patients. If proper notice is not received, we reserve the right to charge a missed appointment fee of $50 in case if an appointment was missed or cancelled within 48 hours. The 3rd missed appointment could result in being dismissed from the practice.

Payments

We accept the following forms of payment: CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS and DISCOVER. In addition, we offer CARE CREDIT, a patient payment program offering a full range of No Interest and Extended Payment Plans for treatment fees.

Payment is expected at the time of your services. If you have dental insurance, we will provide an estimate of your co-payment and collect your portion at the time of your appointment. If an

overpayment is made, you will receive a refund once all claims are processed.

You will receive a statement for balance due within 30 days, as well as, balance due after insurance letter. If you do not, please contact the billing office at 703-671-0626.

A finance charge of 1.5% will be assessed monthly to account balance after 60 days.

Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply. Once accounts are turned over to the collection agency you will be dismissed from the practice. The responsible party of the account will receive notification via certified mail. You have 30 days from receipt of notification to find a new dentist.

Return check fee is $25. We have the right to seek appropriate relief from the court of proper jurisdiction for full payment plus all costs, treble damages, and witness fees in accordance to Virginia law, if payment has not been received within 30 days of notification.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment to your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our staff at any time to discuss any concerns you may have.

Dental Insurance

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist in the cost of dental care. To avoid surprises on your bill, it is important to understand what your insurance will cover, and what you will need to cover in some other way. Dental benefits should not be confused with the dental services you need.

As a courtesy to our patients, we are happy to submit your claims for services. In order for us to do this, you must provide us with accurate and up-to-date insurance information. We will confirm your coverage and plan and we will estimate the insurance portion and your co-payment. This may or may not be what the insurance company will actually pay. Your plan may base its dollar allowance on a usual and customary fee schedule which may not coincide with current fees in our area. We'll do our best to help you receive maximum benefits. Patients are responsible for all balances incurred for services received.

If you are unable to present a valid member identification card from your carrier at your visit, we will expect payment in full until you are able to verify your insurance coverage.

We will wait 60 days for insurance claims to be paid. After 60 days if payment has not been made, you will be asked to pay the balance and seek reimbursement from your insurance company.

Divorce Parents

In the case of a divorce, regardless of decree, the parent authorizing treatment for child(ren) will be the parent responsible for those subsequent charges. We are unable to bill separate parties; therefore it is the parent's responsibility to work out these details of payments.

Patient under the age of 18

Please plan to be present at appointments with your child under 18. If you cannot be there, please make prior arrangements with our staff. The parent accompanying a minor child is responsible for payment. If your child is over 18 and you will not be accompanying him/her to the appointment, please send payment along with your child or call with a card number to run while they are here.

Waiver of Confidentiality

You understand if we submit your account to an attorney or collection agency, if we have to litigate in court, or your past due status is reported to a credit report agency, the fact that you received treatment at our office may become a matter of public record.

Charges for Phone Calls

If a dentist is called, either after hours or during weekends or holidays, for prescriptions or refills a charge of $25.00 may be assessed. Charge is waived if the patient is seen in the office.

Acknowledgement

I have read this Patient Financial Policy as outlined, and understand that I am ultimately responsible for the charges incurred by me or by child(ren) as their legal parent or guardian.

This is an agreement between Dr. Moutaz Abdeen as creditor, the Patient/Guardian, or Parent as debtor, named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Provider

Continue