



# WOODBRIDGE DENTAL CENTER FINANCIAL POLICY

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The Arlington Center for Dentistry's mission is to provide the highest quality care in a comfortable and caring environment to each and every patient. We pride ourselves on our patient-centered practice, where we perform the highest level of care and service in a clean and well-organized environment.

All recommended treatments are in the best interest of our patients. We will not allow your dental insurance to dictate your treatment plan; therefore we will inform you before we perform any recommended treatment.

## DENTAL INSURANCE

We accept assignment of estimated insurance benefits as a courtesy to our patients. You must inform us about your *primary* dental insurance. Please remember that your dental insurance is a contract between you and the insurance company. It is not a contract between the dentist and the insurance company. Our usual and customary fees, which are modest with our geographical area, are a reflection of our commitment to excellence. *All estimated co-pays and deductibles are due at the time of service.*

All insurance claims are submitted within 24 hours. However, we have found that some insurance companies do not reimburse us within an adequate timeframe. After 30 days, we will re-submit the claim as an added courtesy to you. If the claim is still not paid 60 days after, due to any reason, you will be responsible for the total amount. We strongly recommend that you follow up with your insurance company to ensure prompt processing of claims.

Balances remaining after 90 days may accrue interest and may be sent to a collection agency. Arlington Center for Dentistry will not accept secondary dental insurances. We recommend that you read your policy carefully to be fully aware of any restrictions that may apply to your dental benefits. For your convenience, we may process your secondary insurance claim for a small fee of fifteen dollars (\$15) per claim.

## EMERGENCY PATIENTS

Please note that our policy requires verification of insurance. In the event that we are not able to verify your insurance information, payment will be due at the time of service. We will assist you in submitting a claim to your insurance company, so that the insurance company will reimburse you directly for your visit.

## X-RAY AND RECORD DUPLICATION FEE

In the event that you should request a duplication of your dental records or x-rays, you are required to fill out a release form. There will be a fee of \$15 to \$25, depends on the type of x-rays/records you request. Payment is due upon request of duplicating services.

## **APPOINTMENTS**

Your appointment is a time especially reserved for you and for your dental care needs. We strive to give each patient a courtesy call one two days in advance of your scheduled dental visit. However, you are expected to keep your appointment time with or without the courtesy call. Therefore we ask your consideration that you kindly give 48-hour notice if you are unable to keep your appointment is not given. Please note that if 48-hour notice is not given, (by 11 a.m. Friday for a Monday appointment), **there may be a \$75.00 fee for a 30-60 minutes appointment, and \$150.00 fee for a 60-or more minutes appointment is what you will be charged.**

## **PREFERRED METHOD OF PAYMENT**

For your convenience, we accept Cash, ATM/Check cards and all Major Credit Cards – American Express, MasterCard, Visa, Discover, and Checks (with proper I.D.). We also use an automated telecheck service, which electronically withdraws the payment from your account or insures payment. There will be a fifty dollar (\$50) returned check fee applied to your account in the bank denies your check for any reason. As an added courtesy, we also offer a revolving line of credit through a third party (upon credit approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time. Please feel free to ask our business coordinator if you are interested in this type of payment. For treatment plans that exceed one thousand dollars (\$1000.00); *we offer a prepaid discount of 5% when paid in full by cash, ATM/Check card and all Major Credit Cards before treatment begins.*

The parent or guardian that brings a minor in for treatment is the financially responsible party. Financial arrangements between individual parental parties do not absolve the parent bringing the minor from their financial obligation to our practice.

***By signing below, I acknowledge that I have read, understand, and agree to the provisions of the above policy.***

**PATIENT'S NAME:** \_\_\_\_\_

**PARENT/GUARDIAN NAME:** \_\_\_\_\_

(IF PATIENT IS A MINOR)

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_