

PATIENT POLICY

FINANCIAL POLICY

FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, DISCOVER, AND PAYMENT PLANS AVAILABLE THROUGH CARECREDIT AND CHASE HEALTHADVANCE. PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. IF YOU ARE UNABLE TO PAY FOR YOUR SERVICES AT THE TIME OF YOUR APPOINTMENT, PLEASE CONTACT OUR OFFICE 48 HOURS PRIOR TO YOUR APPOINTMENT TO RESCHEDULE FOR A MORE FINANCIALLY SUITABLE TIME. PLEASE REMEMBER YOU ARE FULLY RESPONSIBLE FOR ALL FEES INCURRED IN OUR OFFICE REGARDLESS OF YOUR INSURANCE COVERAGE.

WE WILL SEND YOU A MONTHLY STATEMENT NEAR THE BEGINNING OF EACH MONTH. MOST INSURANCE COMPANIES WILL RESPOND WITHIN TWO TO FOUR WEEKS. AFTER 30 DAYS A NOMINAL FINANCE CHARGE (18%APR) BEGINS TO ACCRUE UNTIL THE BALANCE IS PAID. WE MUST INSIST THAT ALL AMOUNTS BE PAID IN FULL BEFORE 90 DAYS HAVE PASSED FROM THE TIME OF TREATMENT REGARDLESS OF INSURANCE COVERAGE. OUR HOPE IS FOR YOU TO URGE YOUR INSURANCE CARRIER TO PAY THEIR PORTION IN A TIMELY MANNER. WE CAN ESTIMATE YOUR PORTION AND ASK THAT YOU PAY THAT AMOUNT AT THE TIME OF SERVICE. ANY REMAINING BALANCE AFTER YOUR INSURANCE HAS PAID IS ALSO YOUR RESPONSIBILITY. YOUR PROMPT REMITTANCE IS APPRECIATED. THERE WILL BE A \$30 CHARGE FOR ALL RETURNED CHECKS. IF YOU REQUIRE SPECIAL CONSIDERATION OF YOUR ACCOUNT, PLEASE LET US KNOW AT THE BEGINNING OF YOUR TREATMENT. IF YOU HAVE QUESTIONS REGARDING YOUR ACCOUNT, PLEASE CONTACT US AT **804-737-4444 x 13**. MANY TIMES, A SIMPLE TELEPHONE CALL WILL CLEAR ANY MISUNDERSTANDINGS.

INSURANCE FILING

AS A COURTESY, OUR OFFICE WILL FILE INSURANCE CLAIMS FOR ALL PROCEDURES PERFORMED, ON THE BEHALF OF ALL OUR PATIENTS, TO ALL INSURANCE COMPANIES. ***HOWEVER, IT IS VERY IMPORTANT THAT ALL PATIENTS ARE AWARE THAT WE ARE ONLY PARTICIPATING PROVIDERS OF SERVICE FOR DELTA DENTAL, ANTHEM/BCBS OF VIRGINIA AND METLIFE.*** IF YOU HAVE ANY OTHER INSURANCE PROVIDER AND ARE UNSURE IF WE ACCEPT THEIR CONTRACTED FEES, PLEASE CONTACT YOUR INSURANCE COMPANY, OR ASK ONE OF OUR TREATMENT COORDINATORS OR OUR BILLING COORDINATOR. _____

INITIAL

COLLECTIONS

ANY ACCOUNT BALANCE OVER 90 DAYS (3 BILLING CYCLES) IS SUBJECT TO FURTHER COLLECTION ACTION THROUGH CREDIT ADJUSTMENT BOARD. SHOULD FURTHER COLLECTION ACTION BE NECESSARY, A COLLECTION FEE OF 33% OF YOUR OUTSTANDING BALANCE WILL BE ADDED TO YOUR PAST DUE BALANCE TO COVER COLLECTION COSTS INCURRED BY US TO RECOVER YOUR DEBT.

IF AN ACCOUNT IS TURNED OVER FOR COLLECTION, OR WE RECEIVE A BANKRUPTCY NOTICE, OUR OFFICE RESERVES THE RIGHT TO REFUSE FURTHER TREATMENT TO THE PATIENT AND FAMILY. HOWEVER, EMERGENCY TREATMENT WILL BE PROVIDED WITHIN 30 DAYS OF COLLECTION ACTION OR BANKRUPTCY WITH PAYMENT IN FULL EXPECTED AT THE TIME THE TREATMENT IS RENDERED. WE WILL BE HAPPY TO TRANSFER ANY RECORDS TO THE DENTAL OFFICE OF YOUR CHOICE FOR A NOMINAL RECORDS TRANSFER FEE OF \$10 PER PATIENT RECORD.

CONFIRMING SCHEDULED APPOINTMENTS

CONFIRMING APPOINTMENTS IS DONE AS A COURTESY FOR OUR PATIENTS. WE WILL MAKE REMINDER PHONE CALLS OR SEND EMAIL REMINDERS 7 DAYS PRIOR TO YOUR APPOINTMENT. SHOULD THE APPOINTMENT NOT SUIT YOUR SCHEDULE, PLEASE MAKE SURE TO CALL US AT 804-737-4444 x 10 AT LEAST 48 HOURS PRIOR TO YOUR APPOINTMENT TIME. IF YOU HAVE NOT HEARD FROM US BY MAIL OR BY PHONE PRIOR TO YOUR APPOINTMENT, PLEASE CALL US TO VERIFY AND CONFIRM YOUR APPOINTMENT. IT MAY BE POSSIBLE THAT WE DO NOT HAVE CORRECT CONTACT INFORMATION FOR YOU. A BROKEN APPOINTMENT FEE WILL APPLY TO YOUR ACCOUNT AT A RATE OF **\$35 PER APPOINTMENT** TIME SHOULD YOU MISS OR CANCEL YOUR APPOINTMENT WITHOUT 48 HOURS NOTICE.

TREATMENT CONSENT

I AUTHORIZE DR. WHITE AND/OR THWEATT, AS WELL AS ANY OTHER EMPLOYEES OF THIS OFFICE, TO TREAT ME FOR MY DENTAL RELATED NEEDS. I UNDERSTAND THAT DECISIONS CONCERNING MY TREATMENT ARE SOLELY MY OWN. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK QUESTIONS AND HAVE THEM ANSWERED IN A PROFESSIONAL, TIMELY MANNER. I UNDERSTAND THAT IN CERTAIN CIRCUMSTANCES IT MAY BE NECESSARY OR TO MY BENEFIT TO BE REFERRED TO A

E. ALEXANDER WHITE & BRADFORD R. THWEATT, DDS, PC
5500 WHITESIDE ROAD
SANDSTON, VA 23150

SPECIALIST FOR TREATMENT. SHOULD I CHOOSE NOT TO SEEK THE SERVICES OR CONSULTATION OF A SPECIALIST UPON RECOMMENDATION, THAT DECISION AND LIABILITY ARE SOLELY MY OWN. SHOULD A BIOPSY OF ORAL TISSUE BE NECESSARY, I UNDERSTAND THAT THERE WILL BE A CHARGE FOR THE BIOPSY PERFORMED IN THE OFFICE AS WELL AS FEES ASSOCIATED WITH THE LABORATORY, WHICH INSURANCE MAY OR MAY NOT COVER. I CONSENT TO BLOOD TESTING IN THE INSTANCE WHERE A BLOOD OR FLUID CONTAMINATION MAY OCCUR AND PLACE A STAFF MEMBER AT RISK FOR TRANSMISSION OF BLOODBORNE INFECTIOUS DISEASES (E.G. HEPATITIS OR HIV). _____

INITIAL

OUR OFFICE PARTICIPATES WITH THE VIRGINIA PRESCRIPTION MONITORING PROGRAM. WE RESERVE THE RIGHT TO AUTHENTICATE PRESCRIPTION HISTORIES USING THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS WEBSITE.

PHOTOGRAPHS

I CONSENT TO ALLOWING DR. WHITE, THWEATT, AND ANY OF THEIR EMPLOYEES TO PHOTOGRAPH MY TEETH OR FACE FOR THE PURPOSE OF TREATMENT PLANNING, PATIENT RECORDS, AND/OR LAB WORK. _____

INITIAL

VERBAL OR WRITTEN STATEMENTS

I ACKNOWLEDGE THAT ANY COMMENTS OR STATEMENTS I MAKE VERBALLY, IN WRITING, ON THE INTERNET, OR ON ANY OTHER SOCIAL MEDIA CONCERNING OR RELATED TO THE PRACTICE, IT'S EMPLOYEES, DOCTORS, OR OWNERS, BECOMES THE SOLE COPYRIGHT PROPERTY OF SANDSTON COMPREHENSIVE DENTISTRY. _____

INITIAL

BEFORE SIGNING, PLEASE ASK ANY AGENT OF THIS OFFICE IF YOU HAVE ANY QUESTIONS CONCERNING THIS FORM AND/OR ITS POLICIES.

I UNDERSTAND THE ABOVE STATED POLICY AND AGREE THAT I AM THE RESPONSIBLE PARTY FOR THE FEES CHARGED FOR SERVICES PROVIDED.

SIGNED _____ DATED _____

PRINTED _____