E. Alexander White & Bradford R. Thweatt, DDS, PC
5500 Whiteside Road
Sandston, VA 23150

Patient Policy

Financial Policy

For your convenience we accept Visa, MasterCard, Discover, and payment plans available through CareCredit. 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***. If you have any other insurance provider and are unsure if we accept their contracted fees, please contact your insurance company, or ask our treatment coordinators or our billing coordinator.

Collections

Any account balance over 90 days (3 billing cycles) is subject to further collection action through DankosGordon, Attorneys at Law, PC. 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 plus $68.00 processing fees and court costs.

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/text 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 email, text 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 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).

Signature_____Date_____

Print_____

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Prescriptions & Medical Authorizations

Our doctors only call patient prescriptions in to pharmacies between 9 am and 4pm Monday-Friday.

Under a new Drug Enforcement Administration (DEA) rule implemented October 6, 2014, all drugs containing the opioid hydrocodone have been reclassified as Schedule II controlled substances, prohibiting pharmacies from recognizing refills and phoned-in prescriptions for those medications.

Please be notified that any prescriber of schedule II, III, or IV drugs may access program files from the Prescription Monitoring Program. 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.

If you have had a joint replacement, we require specific written instructions from your Orthopedic Surgeon on antibiotic premedication prior to your dental treatment.

If you are on a blood thinner, we require specific written instructions from your doctor pertaining to the suspension or discontinued use of that medication prior to your dental treatment.

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.

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. _____

Disclosure to Family Members and/or Friends

Our patient, _____, has agreed that we may disclose healthcare information related to their health and/or as needed for payment of healthcare services, to:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

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.

Signature_____Date_____

Print_____