New Smiles Dental
FAMILY COSMETIC AND IMPLANT DENTISTRY

1900 Opitz Blvd, Ste C, Woodbridge, VA 22191
450 Garrisonville Rd, Ste 201, Stafford, VA 22554
11111 Leavells Rd, Fredericksburg, VA 22407
www.virginianewsmiles.com

OUR FINANCIAL POLICY

We welcome you to our practice. We strive to provide quality care in a pleasant, comfortable atmosphere. We have found that an important part of your comfort is a clear understanding of the financial aspects of dental care. We will do our best in advance of each procedure to work out satisfactory arrangements to handle the cost of your dental treatment arrangement. **Please read the following and initial each one of them.**_____

1) We accept cash and checks, as well as Visa, Mastercard, American Express, and Discover credit cards. _____
2) We offer financing through a financial institution with approved credit, _____
3) Payment is due in full at the time of treatment unless specific arrangements are made in advance. _____
4) If you don't have dental insurance, we offer a courtesy discount if treatment is over $1000 and is paid in full by cash or check prior to the day of service. Discount does not apply when using a No-Interest Financial Plan. _____
5) NSF Checks: There will be a charge of $35.00 for any returned check. _____
6) In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 1.8% interest per month on all balances which are unpaid ninety (90) days after the services are rendered; plus any and all reasonable costs for collections, attorney's or court costs that may derive from attempting to collect such outstanding balance. _____

INSURANCE:

1) Although insurance can be helpful in covering some costs, please be aware that almost all insurance plans only cover certain percentage for dental services. This will leave you, the patient, responsible for a **copay**. We encourage you to know and understand your benefits and limitations. _____
2) As a courtesy to our patients we will submit any claims to the Insurance Company and apply those payments to the account according to the insurance guidelines. **Copay will be due in full on the date of service** unless previous financial arrangements have been made. _____
3) In the case of Secondary insurance, as a courtesy to you we will send the claim and apply any payments to the account according to the insurance guidelines. Any balance will be billed to you. Any overpayment will be credited to your account. _____

Any unpaid amounts from the insurance are the patient's responsibility. _____
You are responsible for informing the Front Desk staff of any changes on your Dental insurance policy. _____

We hope that this explanation of our financial policies will assist you in feeling comfortable about this important aspect of your dental care. We look forward to a long and happy relationship with you in our practice. If you have any questions regarding our policy or your account, please do not hesitate to discuss it with us. Your cooperation is deeply appreciated. Thank you.

I have read and understand this statement of financial policy.

Signature_____ Date_____

Print Name_____

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OUR CANCELATION POLICY

A reserved appointment time in our dental office is valuable, therefore we require a 48 hour notice to cancel/reschedule an appointment. **Failure to give 48 hours advance notice will result in a minimum charge of $50**. _____**initials**

If your appointment is on Monday, give us a call the prior Friday no later than 1pm to confirm your appointment or cancel/reschedule your appointment. _____**Initials**

Cancelations must be communicated directly to a staff member or through our text message system 48 hours before the appointment to avoid a $50 charge. _____ **Initials**
Cancelations left on voicemail or sent by email with less than 48 hours will be subject to a $50 cancellation fee. _____**(initials)**

We hope that this explanation of our cancelation policies will assist you in feeling comfortable about this important aspect of your dental care. We look forward to a long and happy relationship with you in our practice. If you have any questions regarding our policy or your account, please do not hesitate to discuss it with us. Your cooperation is deeply appreciated. Thank you.

I have read and understand this statement of financial policy.

Signature_____ Date_____

Print Name_____