Virginia Perio
PERIODONTICS AND DENTAL IMPLANTS

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FINANCIAL POLICIES AND DENTAL INSURANCE SERVICES

ALL FEES FOR PERIODONTAL CARE ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED, UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

ALTHOUGH WE DO NOT PARTICIPATE WITH ANY INSURANCE COMPANIES, AS A SERVICE TO YOU, WE WILL FILE ALL NECESSARY INFORMATION TO YOUR INSURANCE COMPANY. IN ORDER TO FACILITATE INSURANCE CLAIMS PROCESSING, WE ARE OFTEN REQUESTED BY INSURANCE COMPANIES TO PROVIDE MEDICAL AND DENTAL INFORMATION PERTINENT TO YOUR CARE IN THIS OFFICE. YOU WILL BE RESPONSIBLE FOR ANY PORTION NOT COVERED. WE WILL GLADLY MAKE FINANCIAL ARRANGEMENTS IF NECESSARY.

ALL DENTAL INSURANCE BENEFITS POLICIES ARE DIFFERENT AND SUBJECT TO CHANGES. IT IS A CONTRACTUAL AGREEMENT BETWEEN THE INSURANCE COMPANY AND YOU OR YOUR EMPLOYER. WE HAVE NO CONTROL OVER THIS RELATIONSHIP. OUR RELATIONSHIP IS WITH YOU, THE PATIENT. MOST DENTAL POLICIES ARE NOT DESIGNED TO MEET THE NEEDS OF COMPREHENSIVE PERIODONTAL CARE.

DENTAL INSURANCE COMPANIES PAY A PERCENTAGE OF WHAT IS TERMED ALLOWABLE CHARGES OR SET AMOUNTS. THEY ARE SET BY THE INSURANCE COMPANIES BASED ON PREMIUMS PAID, AND CANNOT BE CONFUSED WITH FEE LEVELS THAT WE HAVE DETERMINED TO PROVIDE YOU WITH HIGH QUALITY DENTAL CARE.

ALL OUTSTANDING ACCOUNTS WILL RECEIVE A STATEMENT EACH MONTH. DENTAL INSURANCE COMPANIES GENERALLY TAKE FROM TWO WEEKS TO ONE MONTH FOR REIMBURSEMENT. IF YOUR STATEMENT IS NOT REFLECTING ANY ACTIVITY, WE ASK THAT YOU CONTACT US IMMEDIATELY, SO THAT WE MAY EXPEDITE THIS PROCESS. WE ASK THAT YOU PAY ON YOUR PORTION OF THE BALANCE. ANY OUTSTANDING BALANCE OVER 60 DAYS WILL HAVE A FINANCE CHARGE OF 1.5% (18% APR) APPLIED.

YOUR TIME IS IMPORTANT TO US, AND ALL ATTEMPTS WILL BE M ADE TO RENDER TREATMENT IN A TIMELY AND PROMPT MANNER. AS LONG AS WE RECEIVE AT LEAST 24 HOURS NOTICE OF YOUR NEED TO CHANGE YOUR APPOINTMENT, THERE WILL BE ABSOLUTELY NO CHARGE FOR THE BROKEN APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A CHARGE OF $50 PER 30 MINUTES OF APPOINTED TIME. IN THE EVENT MY ACCOUNT IS FORWARDED TO A CO LLECTION ATTORNEY, I UNDERSTAND THAT I WILL PAY ALL ATTORNEY'S FEES, COURT COSTS AND ALL FEES INCURRED IN ANY COLLECTION ACTION. WE WILL GLADLY DISCUSS ANY ASPECT OF OUR OFFICE POLICY.

I UNDERSTAND THAT I AM GIVING MY PERMISSION TO VIRGINIA PERIO LTD, TO RELEASE MY RECORDS TO INSURANCE COMPANIES UPON THEIR REQUEST.

ARE YOU IN ANY BRANCH OF THE MILITARY? YES ◯ NO ◯

PATIENT NAME	**E-MAIL**	**PHONE**
PATIENT SIGNATURE	**NAME**	**DATE**
GUARDIAN'S SIGNATURE IF PATIENT IS MINOR	**NAME**	**DATE**