Financial Agreement / Office Policies

Commonwealth Pediatric Dentistry
a division of Central Virginia Dental Care, PLC

6661 Lake Harbour Drive
Midlothian, VA 23112
804-729-0792 (office)
804-729-0861 (fax)

7032 Forest Hill Ave
Richmond, VA 23225
804-621-8299 (office)
804-932-0009 (fax)

201 A Street
Farmville, VA 23901
434-808-1657 (office)
434-710-4030 (fax)

Payment: Payment is expected in full for each appointment as services are rendered. Payment options are:

- Cash
- Check
- Credit Card (MasterCard, Visa, American Express)
- Care Credit (special financing on approved credit offering no interest plans)

Dental Insurance: Your insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied", or "over UCR". We will file your primary dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusion, and provisions determined by your insurance company. **You agree to be responsible for payment of all services rendered on behalf of myself and/or my dependents**. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination or preauthorization for recommended treatment when it is requested by you**. Note that any insurance predeterminations or insurances estimates are only an estimate**. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payers and/or other health practitioners.

Missed Appointment Fee: A missed appointment is failing to show up for an appointment or changing an appointment with less than 24 hours' notice. When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment to please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved room to another patient who also would like to have their dentistry completed. **There is a $50 charge for each missed appointment. Patients with three missed appointments will be asked to transfer their records to another dental practice.**

Appointment Confirmations: We reserve the right to reschedule and fill any appointment spot that is unconfirmed by 12:00pm/noon two business days prior to the scheduled appointment.

Emergency/After Hours Appointment: If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time services are rendered.

Finance Charge: A finance charge will be added to your account for any balance over $50.00 that is unpaid within (30) days of the date of the service. The FINANCE CHARGE will be computed at the rate of (1%) per month.

Returned Checks: There is a ($35.00) fee for any checks returned by the bank. If this occurs on your account personal checks will no longer be accepted.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, finance charge, and any payments and credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment. We cannot send statements to any other person.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay 33 1/3% attorney fees and all court cost incurred.

Divorce: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Commonwealth Pediatric Dentistry, a division of Central Virginia Dental Care, PLC and the Patient/Debtor named on this form.

In this agreement the words "you", " your", and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for the patient to which charges are made and payments are credited. The words "we," "us", and "our" refer to Commonwealth Pediatric Dentistry, a division of Central Virginia Dental Care, PLC.

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Patients Name

____ _________________________
Parent/Legal Guardian/Responsible Party(printed) date

____ _________________________
Parent/Legal Guardian/Responsible Party (signature) date