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[WWW.ROUNDHILLSMILEDESIGN.COM](http://WWW.ROUNDHILLSMILEDESIGN.COM)

## Financial Policy

Thank you choosing our practice to serve your dental needs. Please take the time to read the following, initial each section then sign and date the bottom of this form.

\_\_\_\_\_ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

\_\_\_\_\_ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a **courtesy**.

\_\_\_\_\_ Insurance balances which are not paid within 60 days will be billed to you. Please keep your walk out statements and follow up with your insurance carrier to ensure prompt payment.

\_\_\_\_\_ Some of your treatment may **NOT** be covered by your insurance carrier. The cost for such charges will be your responsibility.

\_\_\_\_\_ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

\_\_\_\_\_ **Patients are asked to confirm their appointments at least 24 hours in advance by responding to our confirmation contact. Failure to cancel your appointment within 24 hours will result in a charge of \$50 per hour for the time reserved.**

\_\_\_\_\_ There will be a fee of \$30.00 for any check returned for Non-Sufficient Funds (NSF).

\_\_\_\_\_ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

- Collection fees (up to 42% of the full balance)
- Legal fees for collection services

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witnessed By

\_\_\_\_\_  
Date

