Greenway Smiles
43490, Yukon Drive, Suite 114, Ashburn, VA 20147
571-222-4243

OUR FINANCIAL POLICY

Payment of Services:

For patient without dental insurance, full payment is due at the time of services. We offer 5% discount for services if payment was made in cash or check.

For patient with dental insurance, "estimated" co-pay and deductible is expected at the day of the appointment when services are rendered. After insurance claim has been processed, the remaining balance will be billed to you at a later date.

We also offer an extended payment plan with Care-Credit and they required prior approval.

There will be a $25.00 returned check fee per occurrence.

Initial: _____

Regarding insurances:

We will file dental claims on your behalf. However, the balance of your account is your responsibility. Your benefits are in agreement between you and your insurance company, and we are not a party to that contract. Please be aware that services provided may be declined for payment and this balance becomes your responsibility. You have to contact your insurance if having any question about dental payments.

Initial _____

Cancelled/ Missed Appointments:

We maintain a 48-hour cancellation policy for all appointments. It is our policy to charge a $50.00 per scheduled hour for all missed appointments. Please help us to serve our patient's better by keeping scheduled appointments.

Initial: _____

Finance charge:

Finance charges will be applied to all accounts over 90 days at a monthly rate of 1.2%. After the account has been 90 days delinquent, the account will be sent to collections. There will be a collection charge of $35.00 posted to the account as of the day it is sent to collections.

Initial: _____

Disclaimer:

I understand that should this account go to the collection agency, I will be responsible for all reasonable attorney and collection fees.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and agreed to the Financial Policy above.

_____ _____

Signature of Patient / Responsible Party Date

_____

Name of Patient / Responsible Party