LOUDOUN PERIODONTICS
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DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

FINANCIAL POLICY

We feel that everyone benefits when there is a clear understanding of our financial policy prior to treatment.

Patients with Dental insurance:

- Exams and periodontal maintenance cleanings will be billed to your insurance and you will be billed later for any uncovered amounts. At the completion of your examination, an estimate for the cost of any proposed treatment will be presented to you.
- Surgical Procedures
  - **Delta Dental** patients- We will collect the estimated patient portion on the day of service, but any remaining balances after the claim has been finalized will be the patient's responsibility.
  - All **out-of-network** insurance patients- We will collect the **full amount** on the day of your procedure. We will then submit a claim on your behalf and have your insurance company reimburse you directly.

Every effort will be made to collect benefits from insurance companies, but payment of all fees incurred is ultimately the patient's responsibility. We will assist a patient with any resubmissions, but we cannot make telephone calls to the insurance company on the patient's behalf. It is the patient's responsibility to monitor their annual maximum and remaining benefits for the year.

Patients with no dental insurance coverage will be expected to pay in full for all services rendered that day.

- We do not offer in-office financing or accept monthly payment plans, but we do participate with CareCredit. A 9% surcharge will be added to the total treatment cost for the use of this service. Ask our staff for more information if you are interested.

Please note a $5.00 monthly minimum or 1.5% finance charge will be assessed monthly on all unpaid invoices over 30 days.

To the best of my knowledge the information provided to this office is complete and accurate. I acknowledge that all charges incurred in this office are my responsibility. Should my insurance, for any reason, fail to pay for all charges billed, I agree to pay for services upon notification by a representative of this office.

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Signature of Patient and/or Guardian Date