Financial Policies

YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE INDICATES THAT YOU UNDERSTAND AND AGREE TO OUR FINANCIAL POLICIES.

Full payment is due at the time services are rendered.

FOR PATIENTS WITH INSURANCE:

We do accept assignments of your insurance benefits; however, we do require that your co-payment and deductible be paid in full at the time of your appointment. The balance is your responsibility whether your insurance pays for your treatment or not. In the event that your insurance does not pay as much as we anticipate or if services rendered are denied by your insurance company, you are still responsible for the remaining balance on your account. It is imperative that you inform us of any changes in your insurance coverage **PRIOR TO TREATMENT** so that we can provide you with the most accurate estimate.

Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company, and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help.

Any claims unpaid within 60 days of the date of service will become the patient's responsibility.

- *Payments may be made via Cash, Discover, American Express, MasterCard or Visa*
- *A credit card processing fee of **3.5%** will be applied to all credit card transactions. To avoid this fee you may use a debit card or pay with cash.*
- *We offer 6 month interest free financing on transactions over **$1000** through CareCredit.*
- *We do **NOT** accept personal checks.*
- *A charge of **$50 per hour** may be applied to your account for broken appointments, unless a* 48-*hour notice is given.*

I understand the above and agree that if full payment is not made within the 60 day grace period, that I am responsible for the balance. If my account goes to a third party for collection, I understand that I will be responsible for any fees involved in the collection process. This includes but is not limited to court costs and attorney fees in addition to the outstanding balance.

Patient Name: ________________________________ **Date**: _______________________________

Signature: ________________________________ **Relationship to the patient:** ___________________________

Naghmeh Pashmini, DMD
6525 C Frontier Drive, Springfield, VA 22150
P: (703) 313-7000 -- F: (703) 313-7004
serenitydentspa.com