Carino Family Dentistry
7915 Lake Manassas Dr. Ste 201
Gainesville, VA 20155
(703) 754-6622 (Ph)

Financial Agreement

We are committed to providing you with the best possible dental care. In order to begin a long-lasting, professional relationship, we ask for your understanding of and cooperation with our payment policy.

FOR PATIENTS WITH UNITED CONCORDIA, MOST DELTA DENTAL, ANTHEM, HUMANA, METLIFE and PLANS UNDER THE CONNECTION, DENTEMAX DENTAL NETWORKS. As a contracted provider for these plans, we will submit your claims and receive the corresponding payments. You will be responsible for making any estimated co-payments at the time of service. We will be happy to submit your insurance and collect payment from them provided we have verified eligibility. Estimated co-payments, however, will be payable in fill at the time of service. Any remaining balance after insurance payment has been received will be due upon receipt of statement.

We will **ONLY** process primary and secondary insurances if applicable.

For non-insured patients, full payment is due at the time of service unless other arrangements have been made in advance. All arrangements are per occasion and are not to be considered permanent arrangements. Financial alternatives for extensive treatment can be discussed with our front staff and approved by our Office Manager.

We do the best we can to assure the closest accuracy for insurance estimations and coverage. **Ultimately, it is the patient's responsibility to know and understand their dental insurance details.**

OTHER IMPORTANT ITEMS:

When appropriate, we will be happy to submit a pre-treatment estimate to your insurance at your request and after you have provided appropriate insurance information.

1. Interest, at the rate of 1.5% per month, will be applied to all balances exceeding 90 days.
2. Accounts exceeding 60 days since last payment will be reviewed for collection by a third party. **IF YOU RECEIVE A STATEMENT YOU DO NOT UNDERSTAND, PLEASE CALL US IMMEDIATELY. DO NOT IGNORE THE STATEMENT.** Communication is essential to a healthy patient/practice relationship.
3. If an account requires collection by a third party, the patient/guarantor will be responsible for all collection fees (50% of original balance + $25.00), attorney fees, court fees and all/any costs incurred to collect your debt. We sincerely hope these measures will be never become necessary.
4. **A MINIMUM OF $50 WILL BE CHARGED TO YOUR ACCOUNT FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 48 BUSINESS HOURS (Two business days) PRIOR TO NOTICE. OUR OFFICE HOURS ARE MON-THURS 8am to 5pm.** We appreciate your respect for other patients who can utilize your reserved time and your respect for our time. We will extend the same courtesy.
5. Prosthetic cases (crown, bridge, veneer, dentures, partials, etc.) and cosmetic bleaching will NOT be delivered until final payment has been received or specific financial arrangements are on file, including a valid credit card number.
6. A credit report may be requested prior to approving in-office payment plans.
7. There will be a charge of $25 for all returned checks. Checks which are not rectified immediately will be surrendered to a third-party collector for legal action.

If you have any questions concerning the above information, please contact our office. We will be happy to help you.

I have read and understand the above Financial Agreement.

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Patient or Guarantor Signature Date