Carino Family Dentistry

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

Referral Information

Whom may we thank for referring you to our practice? ❒Another patient/Friend ❒Another patient/Relative

❒Dental Office ❒Yellow Pages ❒Newspaper ❒School ❒Work ❒Other

Name of person or office referring you to our practice: _____

Employment Information

The following information is for: ❒The patient ❒Responsible person for the account

Employer Name: _____ Occupation: _____

Address: _____ Phone Number: _____
Street

_____
City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial agreements, must be paid for in cash at the time services are performed.

Patient who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time of condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of patient, parent of guardian Date Relationship

_____ _____ _____
Signature of guarantor of payment / reponsible party Date Relationship