SMALLWOOD
DENTAL SOLUTIONS

Office, Insurance, and Financial Policies

Thank you for choosing our office for your dental needs. We require patients to read and sign the office, insurance, and financial policies before treatment. Please let us know if you have any questions or concerns regarding the following policies.

Insurance: We may accept assignment of insurance benefits after you provide us with your full insurance information and we are able to reach your insurance carrier to verify that information. **We require that you pay your deductible and your estimated patient portion at the time of service.** If your insurance company has not made a payment within 45 days of billing, the balance will become your responsibility. We will file pre-treatment estimates at your request only. Some insurance companies may not honor a pre-treatment estimate or may alter it. Not all services are covered by insurance, in the event your insurance plan determines a service to be "not covered", down-coded" or if "alternative benefits" are given you will be responsible for the differences or for the non-covered charges. It is your responsibility to know your insurance benefits; the practice is not liable when and if there is an insurance discrepancy. Our office does not guarantee your eligibility and coverage.

Dental Insurance: I authorize and release information and payment of my dental insurance to my dentist. The above named dentists may use my health care information and may disclose such information to my insurance carriers.

Minor Patients: The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized for payments via Discover/MasterCard/Visa, cash, or check.

Missed Appointments: We reserve the right to charge $35 per hour for appointments broken without the proper 48 hour notice. Please help us serve you better by keeping your scheduled appointments; broken or missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

Significant exposure: Section 32.1-45, 1 (A) and (B), Code of VA. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus, and Hepatitis Virus is considered to have been given by the patient and/or healthcare worker thereby granting the hospital the right to perform such tests. Test results are confidential and can only be released in accordance with the applicable laws and the policy of the treating hospital.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my account balance and my family member's account balance _____ (names of the family members) including co-payments and non-covered services requested by me or my family members. In lieu of a refund I authorize any credits on my account to be transferred to my family member's account and I understand I will be billed for any outstanding balance after the credit is applied to the family account balance unless otherwise directed. I understand that in the event my account becomes delinquent, I will be responsible for any collections, attorney fees at 25%, court costs, and any other charges incurred to this account (pre-collection fees, etc.). I authorize and release information and payment of my dental insurance to the dentist.

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Signature of Patient or Responsible Party **Date**

CHECK HERE TO RECEIVE APPOINTMENT REMINDERS: **TEXT MESSAGES:_____EMAILS:_____**

Address, City, State, Zip Code:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address:_____