FINANCIAL POLICY

Thank you for choosing John J Andre, DDS,PC & Associates as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

We invite you to discuss with us any questions regarding our services. The best Dental Health Services are based on a friendly mutual understanding between provider and patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

PATIENTS WITH DENTAL INSURANCE

1. As a service to our patient, we will bill your insurance company for your treatments. We collect the insurance portion of the payments directly from the insurance company. We ask that each patient PAY THEIR CO-PAYMENT (AND DEDUCTIBLE IF NOT ALREADY MET) AT THE TIME SERVICES ARE RENDERED.

2. Accepting assignment does NOT mean that we accept as full payment whatever the insurance company pays. The patient is ALWAYS responsible for the full amount charged less whatever the insurance company does pay. Our office routinely does composite (white) fillings, some insurance companies may down grade payment to an amalgam (mercury) rate. We feel that composite fillings are in the patients best interest.

3. We DO participate in Anthem of Virginia, Delta Dental of Virginia, and United Concordia plans. Appropriate adjustments will be made for these programs.

4. If, after 60 days, the insurance company has not paid its portion of the treatment fees, then the patient is responsible for the bill.

PATIENTS WITHOUT DENTAL INSURANCE

1. The doctor provides a valuable service and product to our patients and he delivers only the highest quality dentistry. We ask that full payment be arranged by the time the service is completed.

2. Since our purpose is providing the best possible dentistry, we have several financial options to help you receive the you need and want:

    a. We accept VISA, Mastercard, Discover, and American Express.
    b. We have arranged financing for low monthly payments for qualified patients. If interested, please ask for an American General or Dental Fee Plan application.
    c. For major work over $1000.00 involving extended periods of time, we offer a 5% discount if the work is paid in full at the start of treatment with check or cash and 2% discount on credit card.

I acknowledge that payment is due at the time of service, unless other arrangements are made. If we are unable to verify your dental coverage you are responsible for payment in full at the time of service. I further understand that a 1.25% finance charge (15% annually, min $1.00 per month) will be added to any balance over 60 days. In the event of default, I (we) promise to pay indebtedness, together with collection fees of 33 1/3 %, costs of collection and interest as stated above; and waive Benefit of Homestead Exemption. I also understand that a $30.00 fee may be added to my account for all returned checks and broken appointments with less than 48 hour notice. Please help us serve you better by keeping scheduled appointments.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Name: _____

Signature: _____ Date: _____

Print Name (if different from Patient's name):_____