Roman T. Haueis, DMD, P.C. and Emil P. Christofakis DDS
Short Pump Dental

FINANCIAL and OFFICE POLICIES

The following is a statement of our Financial Policies and different office policies. We require all patients, or their parents/guardian (in case of minors), to read and sign this document prior to treatment being rendered.

Payments

PAYMENT IS DUE AT THE TIME OF SERVICE. We have several financial options available for all of our patients. We accept **CASH, CHECK, CREDIT CARDS (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)** and **DEBIT CARDS.**

Initial________

Insurance

Your insurance requires co-payments to be collected at the time of service. We will bill your insurance company as a courtesy to you. In order for us to properly file your claims, we **must** have the most up-to-date information regarding your insurance coverage. For this reason, you may be asked to present your insurance card(s) at each visit.
Due to the complexities and the ever-changing plan options available to patients today, we are not responsible nor is it possible for us to obtain all insurance benefit information. We highly encourage you to research and be aware of your benefits. These may include but are not limited to WAITING PERIODS, DEDUCTIBLES AND SPECIFIC SERVICES such as bite guards, crowns, replacement of missing teeth (partials, fixed bridges, implants) and fillings (silver vs. tooth colored). Signing this Financial Policy is your acknowledgement that you will be responsible for payment in the event that your insurance denies the service.

Initial ________

Minor Patients

The **adults accompanying minors** (i.e., parents and/or guardians) are responsible for payment at the time of service or balance due after insurance.

Initial ________

Missed Appointments

Unless cancelled at least **48** hours in advance, our policy is to charge **$50.00** for missed appointments.

Initial ________

Preferred Choice of Confirmation of Appointments

Our confirmation system gives us the option to send text messages or send emails. Please provide us with the information for your preferred confirmation method. You can choose one or both means of communication.

Text: ________________________ *email:* ____

Initial ___________

Returned Checks

In the event that a check is returned for insufficient funds, a **$35.00** returned check fee will be added to your account.

Initial ________

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

Initial ________

I have read the above Financial and Office Policies and I understand and agree to them.

____ ____________________
Signature of Patient or Responsible Party Date