EASTERN VIRGINIA
FAMILY & COSMETIC DENTISTRY
757-483-6297 • CHURCHLAND • 3221 WESTERN BRANCH BLVD. • CHESAPEAKE, VA 23321

OUR FINANCIAL POLICY

Thank you for choosing us for your dental needs. We are committed to providing you excellent care, and payment of your bill is part of successful treatment. Our Financial Policy is based on an open and honest discussion of our fees. Please read the following and sign below.

PAYMENT IN FULL IS DUE AT TIME OF THE SERVICE

We offer several options for the treatment that we provide:

(1) We accept Cash, Checks, Visa, MasterCard and American Express

(2) We accept Capital One Healthcare Finance and Care Credit-Patient Payment Plan

USUAL AND CUSTOMARY RATES

We are committed to providing excellent dental treatment to all of our patients. Our fees reflect our commitment to the quality care our patients deserve and are considered usual and customary for the area, regardless of any insurance company's determination.

INSURANCE

As a **courtesy** to our patients, **we will bill your insurance company if you bring in completed original insurance forms and all insurance information.** Your insurance policy is a contract between you and your insurance company. As a health provider, we are not a party to that agreement. In the event we accept assignment of your insurance benefits, **we require that pre-approved arrangements be made on the entire amount.** Insurance policies vary and services provided may not be covered. Our office is committed to helping our patients maximize their benefits. We are always available to answer your questions.

MINORS

Payment for services of the treatment of minors can be made by cash, check, or credit card and is the **responsibility of the adult accompanying that minor.**

MISSED APPOINTMENTS

We at Eastern Virginia Family & Cosmetic Dentistry are empathetic to the demanding schedules of our patients. Be advised there will be a **charge** of $75.00 for missed appointments unless they are cancelled 48 hrs in advance. Once an appointment is made, please remember this time has been reserved specifically for you. This better enables us to serve your needs.

FINANCIAL CONSENT

The patient (guardian) agrees to be fully responsible for total payment of treatment performed in this office. I understand that when appropriate, credit bureau reports may be obtained.

I understand and agree to this Financial Policy and Agreement.

Signature of Patient/Responsible Party ______________________ Date ______________________