

Leesburg Dental Care

Peter S. Lee, DDS & Sue K. Moon, DDS

2 Cardinal Park Drive, Suite 206-A

Leesburg, VA 20175

(703) 771-1515

To Our Patients:

Welcome to our office. We are please that you have chosen this office for your dental needs. We would like to take this time to explain our payment policies. If you have questions, please feel free to ask. Thank you.

OUR FINANCIAL POLICY

The following is a statement of our financial policy, which we would like you to read and sign. We are committed to successfully completing all treatment necessary. Please understand that the payment on your bill is the only way we can continue to provide the best quality of care. We require full payment or any co-payments at the time of service. We accept cash, personal checks, and credit cards.

REGARDING INSURANCE

We accept assignment of your insurance benefits. The balance of your account is your responsibility. Your benefits are an agreement between you and your insurance company, and we are not a party to that contract. Please be aware that services provided may be declined for payment and not considered reasonable and necessary under some insurance plans and this balance becomes your responsibility. If payment is not rendered within 60 days by your insurance company, the balance will become your responsibility.

PAYMENTS ON ACCOUNTS

If there is a balance left on your account and has not been paid by the due date, we will turn the account over to our attorney or collection agency. All charges incurred for attorney fees and/or collection cost will be your responsibility. Please advice there is a \$25.00 service charge on all returned checks.

MISSED APPOINTMENTS

Unless cancelled at **least 24 hours in advance**, it is our policy to charge missed appointments at the rate of **\$75.00 per appointment**.

CONSENT FOR TREATMENT

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent t the proposed treatment.

I have read and agree with the above financial policy.

Signature

Relationship to Patient

Patient's or Guardian's Name

Date