fidel Dental Group

Arlington Office: 5500 Columbia Pike • Suite B • Arlington, VA 22204 •703-575-9899
Washington DC Office: 4400 Jenifer St. N.W. Ste. 335 Washington, DC 20015 202-362-7413
www.fideldentalgroup.com

Office Policies & Financial Agreement

We thank you for choosing our office for your dental care. In order to build a trustworthy relationship for years to come we ask you to take a minute to familiarize yourself with our appointment and payment policies.

1. Appointment times are reserved exclusively for you. We make every effort to see patients on time and request that you extend the same courtesy to us by arriving on time for your appointment.

2. Please inform us of any changes to your appointment time at least two business days in advance or we will consider the appointment broken and charge your account $50.00 per broken appointment. If you find that you are running late please call our office to tell us so. Otherwise we may not be able to see. We reserve the right to decline scheduling any future appointments if there is a history of late or broken appointments.

3. A parent must accompany each minor to a visit to our office. Contact our office if you wish to assign another adult to accompany your child. You may choose whether or not to remain in the waiting area during your child's dental appointment. Children almost do better in treatment without parents present but we are open to having one parent accompany your child.

4. Payment for professional services is due at the time dental treatment is provided so please come prepared to pay your deductible, co-payment, and any fees not covered by your insurance on the day of the appointment. A fee of $25.00 will be charged for returned checks.

5. We will file a claim and bill your insurance for you if we are a participating provider. We will provide you with an estimate in writing of your out-of-pocket responsibility. We always try to maximize your benefits but we highly recommend that you contact your insurance company to review your benefits.

6. For patients covered by insurance plans with which we do not participate (*out-of-network provider)*, we will provide you with a claim for filing so that you may be reimbursed by your insurer. Payment for services will be charged in full on the day service is rendered.

7. If your insurance plan does not cover any portion of the services rendered, the remaining balance becomes your responsibility and is due upon receipt of the explanation of benefit document. If your insurance company does not pay our claim with 45 days of filing a claim then the account balance becomes your responsibility. After your insurance pays its portion of the treatment we send a statement to your address on record. We ask that you pay the bill within ten (10) days of the statement date or a fee of $5.00 will be assessed to your account. An additional $5.00 late fee will be charged to your account for every 30 days your account is past due.. An account which is 60 days past due will be transferred to a collection agency and assessed a charge of $50.00 in addition to any legal and court fees.

8. After completion of dental treatment you may be entitled to a refund. You may choose to keep the credit balance with us for use towards future dental care or have the amount refunded to you. Refund checks are issued in the name of the signer of this document and mailed to the address on record.

Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment, phone numbers and change of personal address.

fidel Dental Group

Privacy Policy

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, a copy of our Notice of Privacy Practices is posted for your review and a copy is available at your request. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Authorization and Consent to Treat Patient and adhere to Office Policies

To the best of my knowledge all the information above is complete and accurate. I understand that it is my responsibility to inform Fidel Dental Group should I have a change in health.

I hereby authorize Fidel Dental Group to perform necessary dental services and to disclose patient information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I agree to pay all related professional charges. Fees not covered by my dental insurance will be promptly paid upon notification from the office according to the financial policy above. I have read and understood this document in its entirety including the office and financial policies and agree to abide by them in full.

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

_____ _____

Please print name Parent or Guardian Date

_____ _____

Signature of Parent or Guardian Date

Other Contacts

Whom should we contact if we are unable to contact you ?

Name _____ Relationship _____ Phone ( ) _____

Name _____Relationship_____ Phone ( ) _____

Staff Initials_____