ALLAN L. BERGANO, D.D.S., P.C.

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OFFICE POLICIES

Patient Name: _____

(PLEASE INITIAL BY EACH STATEMENT)

PAYMENTS

_____ We accept payments in the forms of cash, personal checks, money orders, MasterCard, Visa, Discover Card, American Express and Care Credit Cards.

_____ We accept checks, however for your convenience if your check is dishonored or returned for any reason, we will automatically debit your account for the amount of the check plus a processing fee of **$50.00**.

_____ If you have had a return check in our office, we can **NO** longer accept checks as a form of payment. You will be required to pay by cash, credit card, or money order.

INSURANCE

_____If you have dental insurance, as a courtesy we will file your insurance claim. However you will be responsible for your co-insurance and deductible at the time of service. Our computer software makes an estimate of what your insurance will cover and estimates what will be your "out of pocket" expense. This is only an **ESTIMATE** and it is possible that your insurance may cover less than what is estimated. If this should happen then the remaining balance will be your responsibility to pay.

_____ We verify your insurance eligibility and benefits prior to your visit with us; however, information received from your insurance carrier is **NOT** a guarantee of benefits. **YOU** the patient/policy holder are responsible for knowing your benefits in detail.

_____ We will file your insurance promptly as a courtesy to you. **IF YOU CLAIM IS OUTSTANDING AFTER 60 DAYS, YOU WILL BE BILLED FOR THE REMAINING BALANCE AND YOU WILL NEED TO CONTACT YOUR INSURANCE COMPANY TO RESOLVE THE ISSUE.**

_____ Our office does not accept secondary insurances. We will gladly assist you; however, if you prefer our staff to file your secondary insurance, a **$10 fee** will be charged for each claim as a service.

APPOINTMENTS

_____ It is understood that we may but not required to confirm upcoming appointment dates and times. Our staff will provide a courtesy call to verify your appointment 48 hours prior to your appointment date. The patient understands this is a courtesy and they are ultimately responsible to keep their dental appointments. There will be a $50 charge for broken or cancelled appointments **WITHOUT 24 HOURS NOTICE.**

_____ We understand busy schedules, however; if you arrive more than **15 minutes** late for your scheduled appointment you may be asked to reschedule. This is done out of respect for our other patients that have appointments scheduled. We would also ask that your call ahead and let us know you are running late, and will do our best to still accommodate you when our schedule permits.

(please turn over)

AUTHORIZATION FOR TREATMENT

_____ I give my authorization to the dentist and dental staff to render dental treatment to me that they feel beneficial to my oral and overall health. In giving this authorization, it is understood that my dental condition will be explained to me and options for treatment.

_____ It is understood that I have the right to refuse any treatment options presented; however, with refusal of treatment it is also understood that the dentist has the option to refuse future treatment and even dismiss me from the practice when such a refusal of treatment is seen as detrimental to my future dental health, or compromises the professional ethics of the dentist.

PAYMENT PLANS

_____ We do not offer in office monthly payment plans. However, we do work with a financial party (Care Credit – 0% interest, pay off balance in 6-18 months) to help assist in meeting your financial needs. Credit approval is required.

_____ Any dental procedures that are estimated at **$500.00** or more, we require a half down payment when appointment is made.

DELINQUENT ACCOUNTS

_____ After monthly statements and courtesy calls of past due accounts, we will consider an account delinquent when the balance goes unpaid after **60 days** without a financial arrangement or if financial arrangements have defaulted on the agreed upon arrangement. After **60 days**, past due accounts will be turned over for collection procedures. If your account is turned over for collections, you will be responsible for all collection and/or court fees. All appointments (including family members under the account) will be cancelled automatically.

MISCELLANEOUS

_____ A **$10.00 fee ($20.00 per family)** is required for any duplications of dental x-rays.

_____ If you are transferring to another dentist and you request duplication of x-rays to be forwarded (to either you or your new dentist), your account must clear of any current or past due balances (including the duplication fee) before your x-rays are transferred.

NOTICE OF DEEMED CONSENTS FOR INFECTION DISEASE TESTING

_____ Virginia code section 32.1-45.1 provides that when either a person providing healthcare service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immunodeficiency (which caused acquired immunodeficiency disorder syndrome), or hepatitis B or C virus, such other person has deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, an actual consent is not required

Each undersigns represents they have read and fully understand the meanings and effects of Dr. Allan L. Bergano's Office Policies.

_____ _____

(Signature of patient/guardian/date)(If guardian, relationship to patient)