GREEN DENTAL
OF ALEXANDRIA

Financial Policy

It is our policy to provide an “estimate” of necessary treatment. The estimated fees will be honored for up to six months from the estimate date. This will enable you to know what services are planned, as well as, what your financial responsibility will be. **Our financial policy is as follows**:

Payment: We require that **full payment** be made at the time of appointment. We accept cash, personal checks, Visa, Master Card and American Express. We offer payment plans through Care Credit and in house financing.

Insurance

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided *to you, our patient, and not to an insurance company*. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can help in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are **due in full from the patient.**

Broken Appointment Charge:

We have all reserved a significant amount of time just for you. Our philosophy is to allow ample time to do a thorough job and we do not rush anybody. While we realize that circumstances may arise that prevent you from keeping your appointment, we require **48 hours notice** so that we may accommodate other patients. Otherwise, you may be charged a **broken appointment fee of $50 per hour** to partially offset our lost time and expenses. We hope you understand and thank you very much for your cooperation.
In addition, please be advised that for long appointments (1hr or more) a deposit is required.

I have read the financial policy and understand the said terms regarding payment for services, insurance and broken appointment charges.

I hereby authorize that I (or my dependent) have insurance coverage and assign directly to Green Dental of Alexandria all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____