**ARCOS VELASTEGUI DENTAL ASSOCIATES PLLC**
**AV Dental**
**1701 CLARENDON BLVD., SUITE 220**
**ARLINGTON, VA 22209**

## FINANCIAL POLICY

Thank you for choosing us to provide for your dental health. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.
* Full Payment is Due at Time of Service
* We Accept Cash, Checks and Credit Cards

**REGARDING INSURANCE:**
You are required to pay the deductible and % that insurance does not cover at time of service. We do accept assignment of insurance benefits and will be happy to submit a claim form to your insurance company for you. We cannot bill your insurance unless you bring all insurance information and, if needed, an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our office strives to provide quality, dependable, and esthetic dental care. The "least expensive" insurance solution is seldom in the best interests of patient health. It is important to understand that insurance companies draw all contracts with the patient's employer. Their plan may not fit your overall dental health requirements. They can and do apply clauses that limit their level of coverage, placing sole payment responsibility on the patient. If problems arise, our front office staff can suggest some steps toward improving your dental plan. Any balance owed after insurance pays is your responsibility. If your insurance company has not paid your account in full within 45 days, the balance is then your responsibility. Please be aware some and perhaps all of the services provided may be non-covered services under your insurance policy. Secondary insurance is submitted after primary insurance payment has been received.

PRORATED BENEFIT:
Some insurance companies may limit their coverage by a prorated benefit clause. They may base their partial denial on a very narrow range of arbitrary factors. The insurance company is not competent to diagnose, but they can apply their rules to the policy. Any payment denial reflects only the Insurance company's reticence to pay and not lack of need for rendered treatment. Full payment is still required.

USUAL AND CUSTOMARY RATES: (UCR)
Our practice is committed to providing the best treatment for our patients and our fees are competitive for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of UCR.

PRE-TREATMENT ESTIMATE:
We will estimate the insurance portion and the patient portion of charges to the best of our expertise. This is an approximate computation of probable cost and does not guarantee payment by the insurance company. The patient is ultimately responsible for payment in full.

MINOR PATIENTS:
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS:
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments a fee of $50.00. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to the terms of this Financial Policy.

X ______________________________________________ Date: ______________

Authorization by Patient or Responsible Party