SMILES BY MIA
COSMETIC & GENERAL DENTISTRY

(703) 323-1300
8989 Fern Park Dr.
Burke, VA 22015

Office Financial Policies

Dear Patient,

The primary goal of our practice is to provide the highest quality dental care to our patients. Since our practice also has financial obligations which must be met, we ask you to note the following statements of our financial policy.

Treatment Plans and Estimates:

Treatment plans are merely an estimation of planned procedures diagnosed before treatment and can change as treatment progresses. It is often impossible to predict the exact cost of the treatments until they are rendered.

Methods of Payments:

Cash, Check, VISA, Master Card, Discover, American Express, Care Credit, Lending Club.

Co-Payments will be collected at check-in prior to you having treatment rendered.

A credit card will be required to be kept on file for Administrative Charges below. Rest assured; we will never disclose this credit card information to anyone else.

Administrative Charges:

Checks returned by the bank per incident	$35
Account balances over 90 Days	$25
Missed and cancelled appointments without proper notice	$50 per hour
Collection agency fees	1.9% per month
Any X-Ray copy requests	$20

**No cancellations can be left on the voicemail. Cancellations must be made during business hours (Monday-Thursday) 3 business days in advance.

**Collection agency: Patient is responsible for all fees incurred, including attorney & court costs. (Interest rates will be assessed at a rate of 1.9% per month.)

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Dental Insurance:

- Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexity of insurance contracts. As a courtesy to you, we will file dental insurance claims on your behalf, but you will be fully responsible for your account if the insurance company does not pay.

- Your insurance plan is a contract between you (or your employer) and the insurance company. Specific questions about eligibility and plan coverage should be directed to your insurance or your employer.

AUTHORIZATION

I have read and fully understand the above information. I understand that I am responsible for (regardless of insurance coverage) any charges incurred from serviced rendered. I agree to be responsible for all charges not paid by my dental plan. I hereby authorize Smiles By Mia to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

I have read this office policy. I understand and agree to the terms of this financial policy.

Patient Name (Please Print) _____

_____ _____

Signature of Patient or Financially Responsible Party Date