Office Policies

We commit to providing quality, compassionate and professional care to your child(ren). It is our goal to provide the highest level of care to all children regardless of race, religion, sex, national origin, disability or insurance status. In order to maintain these standards, the following policies are in place to maintain the integrity of our interactions with you and your family. Please understand it is our desire to serve your needs to the best of our abilities and we need your assistance in developing a harmonious relationship.

Payment is due when services are rendered if we do not expect insurance to cover all costs associated with treatment. Due to the increased number of patients defaulting on their bills, it has become necessary to obtain payment in advance for any restorative work required. If you have private insurance, you will be required to pay your co-payments and deductible prior to scheduling your child's next appointment. If you do not have insurance you will be required to pay half of the estimated treatment plan charges in order to schedule your child's next appointment.

Please be aware that **24-HOUR NOTICE** is required if you need to change an appointment. If your child or children miss or reschedule less than twenty four hours prior to **ONE SEDATION OR GENERAL ANESTHESIA VISIT, ONE EMERGENCY EXAM, OR TWO APPOINTMENTS OF ANOTHER TYPE**, we will not reschedule your child or children for additional appointments. Your child or children will no longer be considered patients of record. This policy is enforced if the missed appointments are the same day or different days. Missed appointment fees ($230) will be applied to your account. Repeated reschedules will be treated as missed appointments and the same policies will apply.

It is very important that children maintain periodic dental visits. Dental disease progresses very rapidly in primary teeth. Failure to maintain consistent care puts your child at risk for dental emergencies and periodic examinations are vital to staying healthy. Missed appointments and/or untimely scheduling will cause your child to be inactivated as a patient in this practice. Inactivated patients will not be reactivated.

Overdue accounts greater than thirty days will be subject to collections charges ($87), interest fees (compounded monthly at 6%) and any court costs associated with recovering due funds will also become your responsibility. Failure to make timely payment will result in collection action. Overdue accounts will no longer be considered patients of record. A $37.00 returned check fee will be applied to your account if insufficient funds keep your check from clearing. You will also be prosecuted criminally by the county of Albemarle.

This practice will submit insurance claims on your behalf as a courtesy. If insurance doesn't reimburse fully within 30 days you are immediately responsible for payment in full. Insurance payment doesn't always coincide with our best estimate of amount owed. We do our best to coordinate your benefits with amount owed but all quoted estimates are not guarantees of your particular insurance reimbursement and your benefits may be different. It is your responsibility to verify all insurance reimbursement for any procedure treatment planned if you have concerns about your coverage. Many insurance companies do not pay the difference between white fillings (composites) and silver fillings (amalgams). You are responsible for any difference in cost since composites are more expensive to place. Please contact your insurance company if you have questions regarding their payment policies.

If an employee of the practice is accidentally contaminated with your child's body fluids (blood, saliva, vomit, mucus, etc.) your signature on this form gives permission for us to get your child's blood drawn for infectious disease status as defined by Virginia law and authorizes the testing facility to release the test results to the injured employee.

Your signature on this form affirms that you understand these policies, have had the opportunity to have questions answered to your satisfaction and will comply with all items. You also agree to be responsible for all account balances.

Parent/Legal Guardian Signature_____

Date:_____