Graham Rose, DDS Martine Rose, DDS

2010 Bremo Road, Suite 121, Richmond, Virginia 23226

Telephone: 804-282-9191 Fax: 804-282-9195

MISSED APPOINTMENTS

We require at least 24 hours notice if you must cancel an appointment, failure to do so may result in a broken appointment charge of $25.00 per half hour of your missed appointment. Once an appointment has been made, please remember this time has been reserved specifically for you.

SERVICE CHARGES

Be advised our office policy is to charge monthly interest of 1.5% (18% Annual Percentage Rate). This will be applied to all accounts over 90 days, regardless of the insurance involvement. There will be a $25.00 handling fee for any returned check.

INSURANCE ASSIGNMENTS

Our office participates with or is able to accept many (but not all) insurance company assignments. Patients are required to pay their estimated copay at the time of service. Estimates provided by this office are considered a guideline and are not a guarantee of payment. Our office will submit the patient's claim promptly after treatment. Any balance not covered by the patient's insurance company is the patient's responsibility.

COLLECTION FEE

The office does pursue legal action when an account is delinquent. Should this account become delinquent, the patient (or parent/guardian if patient is a minor) agrees to pay all collection and court costs, including attorney fees in the amount of 1/3 (one third) of the unpaid balance.

NOTICE OF PATIENT PRIVACY

A copy of the Health Insurance Portability and Accountability Act (HIPAA) is available upon request. Please ask a staff member if you would like a copy for your records.

FINANCIAL CONSENT

I agree to be fully responsible for total payment of procedures performed in this office, including any treatment not a benefit of any dental insurance the patient may have. I certify that I have read, understood, and agreed to this. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I authorize and release any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Print Patient's Name: _____

Signature_____ Date _____

(Patient, Parent or Guardian sign above)