FALLS CHURCH COMPREHENSIVE
FAMILY DENTISTRY
Fadwa Nassar, DDS, PLLC
6400 Arlington Boulevard. Suite 944
Falls Church, VA 22042

Financial Policy

Thank you for choosing Falls Church Comprehensive Family Dentistry as your heath care provider. We are committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment. It is important that your account be handled properly in order to keep charges as low as possible. Your cooperation in this is appreciated. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

FALLS CHURCH COMPREHENSIVE FAMILY DENTISTRY OFFERS AN EXTENDED PAYMENT PRIOR TO CREDIT APPROVAL

Regarding Insurance

It is the patient's responsibility to provide us with up to date insurance information at the time of each visit. When this information is given, we may accept assignment of benefits, however, we do require that you pay any co-payment, deductible or fee due.

All charges are your responsibility. As a courtesy to you we will submit claims to your insurance company and may accept assignment of benefits. If, however, your insurance company reduces the amount of, or denies the claim for any reason, the balance of the claim will be your responsibility.

Your insurance policy is a contract between you and your insurance company. Falls Church Comprehensive Family Dentistry is NOT a party to that contract.

Falls Church Comprehensive Family Dentistry may accept assignments of your insurance. Your options would include full payment with a check or cash, payment by credit card or pre-approved extended payment plan. If your insurance company has not paid your account in full within 60 days, the balance will be paid by the option you selected.

Please be aware that some services may not be covered by your insurance plan. This means that you are responsible for the bill.

Regarding insurance plans where we are a participating provider, all co-pay is due at the time of treatment. In the event that your insurance coverage is to a plan where we are not participating providers, you are responsible for full payment.

Assignment of Benefits

I request payment of insurance benefits to Falls Church Comprehensive Family Dentistry. I understand that I am financially responsible for all charges not covered by insurance. I acknowledge responsibility to provider Falls Church Comprehensive Family Dentistry with current patient information as well as current insurance information. I hereby authorize the release of any medical information necessary to process all claims.

Usual and Customary Rates

Falls Church Comprehensive Family Dentistry is committed to providing the best treatment for our patient. Our charges are based on cost or what is usual and customary arbitrary determination of usual and customary rates.

Collection Efforts and Fees

If a balance exists on your account past 75 days from the date of service, Falls Church Comprehensive Family Dentistry may transfer your account to a collection agency. This will be done at our option and any costs associated with the collection services will be added to your account.

Minor Patients

The adult accompanying a minor and parent (or guardian of the minor) are responsible for full payment. For unaccompanied minors non-emergency treatment will be denied unless charges have been pre-authorized to any approved payment plan, or payment has been received to required consent forms.

Missed Appointment

After your first missed appointment in any twelve month period. Falls Church Comprehensive Family Dentistry reserves the right to charge a $50 missed appointment fee, the amount of which is reviewed on any annual basis. This fee is not covered by insurance and would be your responsibility. In order to avoid this charge, any necessary cancellations must be made at least 24 hours in advance. Please help us to serve you better by keeping scheduled appointment.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date_____

Signature of patient or guardian