Highland Family Dental Care

Dr. Fay Nazari
13360 Clarksville Pike, Highland, Md. 20777
Phone: 301.854.2000 Fax: 301-854-1122
www.highlandfamilydental@yahoo.com

Office Financial Policies

We strive to provide the highest quality treatment. The following information is our office financial policies to make your visit easier. Please read them carefully and let us know if you have any questions.

Payment Methods/ Refunds:

Cash
Credit card: Visa, Master Card, Discover
Personal check (you must have proper ID, and your name printed on the check)
Care Credit, finance company
Prosper Healthcare Lending

Payment in full is expected as services are rendered. When a refund by credit card is requested a merchant fee of 1.2% will be assessed to the refund. If you have a credit on your account and wish to be reimbursed a check will be given at the end of the month.
There will be a fee of ***$37.00*** for processing a returned or NSF check.
INITIAL HERE _____

Medical/Dental Record Copies:
Patients have the right to sign a record release to obtain copies of their records. However, there is a fee for copies of the records.
INITIAL HERE _____

Fees for Service:
The practice does participate in many PPO insurance plans but provides a service where the practice bills the insurance company directly on behalf of our patients. The patient's ***estimated*** portion is collected **at the time of service**. This fee is based off of the primary insurances fee schedule and coverage is estimated between primary and secondary insurances. The claims submitted to insurance(s) are not a guarantee of coverage from your insurance company and are subject to review by them. If the patient has two insurances we must bill to primary insurance first then once they have returned the claims with the EOB, then they will be sent off to the secondary insurance company. Lab fees are not always a covered service with insurance companies; therefore it will be the patients' responsibility. Patients that do not have insurance are given the office fees. ***These fees are non-negotiable***, and are due at the time of the appointment. Our skilled client service representatives will be able to assist you in planning out your fees. If a patient starts a treatment (i.e. impressions, appliances, etc), and decides not to continue the treatment the fee for the materials and the lab will be applied.
INITIAL HERE _____

Account Balances:
Patients that have balances please note there is a service charge of 1.5% per month on all accounts exceeding 60 days, unless previous arrangements are made. If the account is sent to collections, there is a 30% collection fee. If a suit is filed, the patient agrees to pay attorney fees, court costs, and other expenses incurred as a result of said collections. **If the patient is a minor**, the parent or guardian of the minor signing this form will be responsible to pay the balance at the time services are rendered, unless prior arrangements have been made.
INITIAL HERE _____

Emergency Patients/After Hours:
Patients calling in with an emergency will be triaged over the phone. If it is deemed necessary to come in to the office these patients may have a longer than normal wait time. Patients that are scheduled after hours will have the visit charged to insurance and then any fee will be the patients' responsibility.
INITIAL HERE _____

Short Notice Cancellations, Broken Appointments, and Tardiness Saturday Hours:
A fee no less than ***$60*** will be placed on the accounts for patients who have no-showed or have a less than 24 business hour notice of cancellation. Business hours do not include holidays. Cancelled or broken appointments will have the charge applied to the account

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and it will **not** be waived. For appointments that are longer than one hour there is a $60 charge **per hour**. If you are late to the appointment by at least 10 minutes a $35 fee will be assessed. If you would like to schedule a Saturday appointment there will be a charge of $50 for cleanings, or if you have work to be done those estimated fees will taken at the time the appointment is made. These are nonnegotiable and non-refundable fees for any reason.

INITIAL HERE _____

By signing below, I have read and understand that I am responsible of the terms in the Financial Policy of the office. I also understand that I am responsible for maintaining current personal demographic information including insurance(s). I grant the office permission to contact me by all means necessary (phone, email, text) to discuss matters related to this form.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Printed Name of Minor