119-A University Blvd, Harrisonburg, VA 22801
Office Phone: (540) 434-8575

FINANCIAL POLICY

Thank you for choosing us to provide your dental care. We consider it an honor that you have chosen us to do so. It is of utmost importance to provide our patients with open communication especially, with the area of finance. If you have any questions or concerns about this Financial Policy please do not hesitate to ask our office staff.

PAYMENTS

We accept cash, personal checks, Visa, MasterCard, American Express, Discover, Care Credit and Simple Pay.

FINANCE CHARGE

Interest of 1.5% will be applied to all balances after **60 days** of the service date at the end of each month.

OVERDUE ACCOUNTS

Effective March 5,2014, any account that is 60 days overdue will immediately be turned over to **Valley Credit Services**, a third party collection agency, in which **they** will charge a penalty of **25%** to the current principle. In the event this occurs, you agree to pay collection costs, court cost and/or attorney fees incurred in attempting to collect this amount. In the case your account is turned over to Valley Credit Services, you will be required to make pay the agency directly. We will not accept payment at this office due to our contract with Valley Credit Services.

DENTAL INSURANCE

As a courtesy to our patients, we will submit a pre-treatment estimate and file your claims. Although we may receive a verbal and/or a hard copy of the estimate, please keep in mind, it is just an estimate. The benefit payable is not actually determined until your claim is received and processed by your insurance carrier. Any charges that are not paid by your insurance company are your responsibility, regardless of the reason for nonpayment. Please keep in mind your insurance policy is a contract between you and your insurance carrier. **Payment is due in full when services are rendered and your insurance company reimburses you for the portion they cover.**

CANCELLATION POLICY

We strive to spend an inordinate amount of time with our patients because we are committed to providing individualized attention and want to respect their time. If a previously scheduled appointment does not work as you had planned, we appreciate and anticipate that you will contact us as soon as possible, **failure to give a 24-hour notice will result in a $50 charge being placed on your account.**

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I have read and understood this document in its entirely, outlining office policies of Shenandoah Valley Implant Institute, LLC. Without any reservations, I agree to abide by the policies outlined.

Patient's Name____

Patient's Signature____

(If minor parent or guardian signature)

Date____________________