

1705 South High Street  
Harrisonburg, VA22801  
540-438-1234

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## Angelopoulos Dental PLC

### Financial Guidelines

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

**PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICE IS RENDERED**, unless our staff has approved payment arrangements in advance. We accept cash, checks, all major credit cards, Care Credit and Chase.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover. It is your responsibility to know your plans policies and exclusions.
3. We can maintain computerized histories of payments made by insurance companies, they do change: therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on our most up-to-date information. Any quote given is **AN ESTIMATE** only. It is your responsibility to inform us of any changes with your insurance at each visit.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of dental insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account since all accounts over 90 days are turned over to our collection service for payment. In the event that your account is turned over for collection, you will be responsible for all collection service fees, interest and all legal fees associated with collecting the account, including but not limited to attorney's fees and all court cost. **I further understand that I may be billed for appointments not cancelled 24 hours before my schedule appointment time.**

In addition to the above, I understand that I may be charged a reasonable fee for the copying of my dental record for any purpose. I understand that I may also be responsible for the cost of postage if necessary. Angelopoulos Dental will also retain my dental records for a period of six years from the date of my last visit, after which Angelopoulos Dental may destroy my records according to Virginia laws and regulations.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

I authorize the release of any medical or other information necessary to process my claim. I also authorize payments under my insurance programs to be made directly to Angelopoulos Dental for any services furnished to me.

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Patient Signature (or responsible party)

Date

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Patient Name (or responsible party) (please print)

Date