OFFICE POLICIES

INDEMNITY AND PPO INSURANCE

As a courtesy to our valued patients, our office will DIRECTLY BILL INDEMNITY AND PPO INSURANCES for services rendered. We do ask our patients to be prepared to make any payment towards their basic and major services, such as fillings and crowns, at the time these services are rendered. Our practice is committed to providing the best treatment for our patients and to charging what is usual and customary for our area. Please understand that you are fully responsible for all treatments rendered, including services payable by your insurance company as determined by your employer.

DISCOUNTED PLANS

Discounted plans, such as Kaiser, Signature, and Capital Care, are dental plans which allow patients to receive dental services at a discounted price. IN ACCORDANCE WITH YOUR CONTRACT, PAYMENT IN FULL IS REQUIRED AT THE TIME SERVICES ARE RENDERED.

INSURANCE POLICY

Our office will make every attempt to collect payment for your insurance company. In the rare event that your insurance company does not pay within **60 days** of the date of service, the patient will be responsible for the balance in full, which will be charged to the credit card number listed at the bottom of this page. By signing below, you, the patient, authorize Dr. Jason Favagehi, D.D.S., and Associates to charge the credit card listed below with any balances unpaid by your insurance company within **60 days** of the date of service.

TYPE OF PAYMENTS ACCEPTED

Cash and checks are accepted. Please note there is a $40.00 fee for returned checks. The major credit cards American Express, Visa, Mastercard, and Discover are also accepted.

SCHEDULING AND CANCELLATIONS

Because we value the time spent with our patient's appointments that you make are reserved solely for YOU AND THE DOCTOR. Please give our office the consideration to fill your reservation should you need to cancel. Please allow our office a notice of at least **48 hours** for any cancellations. **Please note that Saturday and Sunday DO NOT constitute business days. Any notice less than **48 hours** will be subject to a $75.00 per half hour broken appointment fee

FINANCIAL AGREEMENT

I understand that all information on patient registration form is required to fill out in order to be seen and to the best of my knowledge, the information provided to this office is complete and accurate. I acknowledge that ALL charges incurred in this office are my responsibility and due at the same time. If, for any reason, my insurance should fail to pay for all charges billed, I agree to pay for services upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of 30 days, it may be referred to an attorney for collections, and I will be responsible for all costs incurred, including a 35% attorney's fee (minimum of $50.00) and interest at 1.5% per month (18% annually).

DUPLICATION OF RECORDS

In the event that your records need to be transferred for any reason other than a referral from our office, there may be a charge of $25.00 per set of x-rays. The fee is assessed to cover the cost of duplication materials. Please allow our office 3-5 business to duplicate any x-rays. We are required by law to keep your records on file for a period of 7 years.

Signature________________________ **Credit Card #**________________________

Date________________________ **Exp. Date**________________________

Rosslyn Dental Arts Center
1000 Wilson Blvd. #M745
Rosslyn VA 22209
(703)527-6453

Tyson Dental Arts Center
8304-C Old Courthouse Rd.
Vienna VA 22182
(703)356-1200

Crystal Smile
2611 S. Clark St. #200
Arlington, VA 22202
(571)295-4200

Crystal City Dental Arts Center
1235 S Clark st. #201
Arlington VA 22202
(571)267-1400