Sameh Kassem, DDS, PC
19490 Sandridge Way Suite 110 Lansdowne, VA 20176

Financial Agreement

We, Riverside Dental thank you for choosing us as your dental provider. Our main reason for being here is to help you achieve optimum dental health, and working together we will reach that goal quickly and efficiently. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patient's financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office at (703) 729 -7447.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof or insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment of services will be due at time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, check, MasterCard, Visa , Discover) A $35 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. As a courtesy, we bill your insurance and help receive the maximum allowable benefits under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers sometimes prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of a claim or appeal of these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contacted with your carrier, we will not negotiate reduced fees with your carrier.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

BROKEN APPOINTMENT

We know that sometimes occasions occur that will make it impossible to keep your dental appointment. We ask that you give us 24 hours' notice, so that we can help another patient who is waiting for an appointment.

There will be a **$50.00 broken appointment fee** charged to patients whom continually abuse their appointments.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collection if such action becomes necessary.

Patient Name: _____Date: _____

Signature: _____

(Parent or Guardian)