

**DR. RAYMOND R. NILES, JR. D.D.S  
AND ASSOCIATES**

**OUR FINANCIAL POLICY**

Thank you for choosing us as your dental providers. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

If you are a continuing patient with us please update any information concerning your medical history or insurance that may have changed since your previous visit and read and sign this statement if you do not have one on file.

All patients must complete our Information and Insurance form before seeing the doctor.

**ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE**

WE ACCEPT CASH, CHECKS, or VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND CARECREDIT ( ***INTEREST FREE FINANCING***). A 5% CASH DISCOUNT IS AVAILABLE FOR BALANCES OVER \$500 IF PAID AT THE BEGINNING OF TREATMENT.

**Regarding Insurance:**

If you have insurance coverage, as a courtesy, we will be glad to file the necessary forms for payment or reimbursement, with your cooperation. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days of the billing date, the balance will incur a service charge of eighteen percent (18%) per year (1.5 % per month). ***Please be aware that some, and perhaps all, of the services provided may be non-covered services.*** Payments under Financial Agreements entered into with out office must also be made in a timely manner and are subject to the same terms hereunder. Any returned checks will incur a \$25.00 service fee.

In the unlikely event collection on a patient's account might become necessary, our reasonable costs associated therewith (including collection fees/costs both pre-and post-judgment entry), attorney's fees, and any associated court fees (all of which are estimated to total 25%-30% in addition to any outstanding balance), will become the patient's obligation. As a patient of our offices located in Woodbridge, VA, you are also consent to jurisdiction and venue in Virginia and Prince William County itself, as well as this agreement being interpreted and enforced under the laws of Virginia. This is the entire agreement between the parties, and may not be altered, except as acknowledged by the parties in writing.

**Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Missed appointments**

**Initial \_\_\_\_\_ Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments. A charge of \$50 will be added to your account. In addition to the cancellation fee, our same day cancellation policy is – First occurrence - A verbal warning of office policy, Second occurrence – A verbal notice of same day appointments. Third occurrence – We will no longer schedule any appointments, however the patient may call the day he would like to come in and see if we have an opening.**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy

We look forward to have you and your family as our patients and continuing to render the quality care you expect and we strive to provide.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Responsible Party