

## Financial Policy

This is an agreement between Joseph M. Arzadon, MD, DDS, PC as creditor, and the Patient/Debtor named on this form.

FINAL responsibility for all payments rests with the patient. Joseph M. Arzadon, MD, DDS, PC will not be held liable for ensuring the accuracy of insurance information, including, but limited to, verifying current coverage and eligibility, obtaining authorizations, or confirming co-payment and/or deductible information.

By executing this agreement, you are agreeing to pay for all services that are received.

### Payment options if you have no insurance:

- You choose to pay by cash, check, debit, or credit card on the day that treatment is rendered.
- CareCredit (*subject to credit approval*) – the financing plan we offer as a separate line of credit to cover for your healthcare needs.

### Payment options if you have insurance:

- You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check, debit, or credit card.
- You choose to pay all of your treatment by cash, check, debit, or credit card. We will request your insurance carrier send their payment directly to you.
- CareCredit (Subject to credit approval) – the financing plan we offer as a separate line of credit to cover your healthcare needs.
- If we are an out of network provider for your insurance company then we will request at least 50% of the fees at the time of service, which will include any deductible that has not been met.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge and any payments or credits applied to your account during the month. Payment will be due within 20 days from the statement date.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable within 20 days from the statement date and is past due if not paid by the end of the month.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Required payments:** Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

*The Financial Policy continues on the back side of this page.*

**Patient's Name:** \_\_\_\_\_

**Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Responsible Party (If other than the patient): \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

SSN / License No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

(over)

**Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The *finance charge* will be computed at the rate of one percent (1.0%) per month or an *annual percentage rate* of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1.0%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$0.50.

**Insurance:** Insurance is a contract between you and your insurance company. Our Practice is not a party to this contract. In most cases, we will send a claim to your primary insurance only as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You agree to pay any portion of the charges not covered by your insurance plan. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower benefit from the insurance company. If our Practice does not get any payment from your insurance company within 90 days from the date your claim was submitted, then you will be responsible for the account in full, within 20 days from the statement date.

**Credit History:** You give our Practice permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. In the event your account is placed with an agency for collection purposes, you will be responsible for all collection agency fees (30% of the balance placed for collection). In addition, you will be responsible for all court costs, filing fees, and attorney fees should your account require litigation. In case of suit, you agree the venue shall be in Arlington County, Virginia or Prince William County, Virginia.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Returned checks:** There is a fee (currently \$30) for any checks returned by the bank.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent responsibility to collect from the other parent.

**Copying of Records:** You will need to request in writing, and there will be a charge of \$10 handling fee PLUS \$.50/page for the records to be released. You authorize us to include all relevant information, including your payment history.

**Workers Compensation:** We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.