Dental Group at Reston Station

Patient Information, Consent for Services & Financial Agreement

Patient Name: _____ Date of Birth: _____
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Email Address: _____ May we contact you by E-mail? ☐ Yes ☐ No

Address: _____
Street City State Zip

Patient Employer Name: _____ Occupation: _____

Employer Address: _____
Street City State Zip

The following is for: ☐ the patient's spouse and/or ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female Date of Birth: _____
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Best time to call: _____

Address: _____
Street City State Zip

Employer Name: _____ Occupation: _____

Employer Address: _____
Street City State Zip

Additional Contacts: _____

_____

Whom may we thank for referring you to our practice? _____

1886 Metro Center Drive, Ste. 600 | Reston, VA 20190 | T. 703-318-8200 | F. 703-318-0834

CONSENT FOR SERVICES AND FINANCIAL AGREEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A $35 fee will be assessed for returned checks due to insufficient funds.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy this office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. All verification of filings, follow through and confirmations of coverage, payments made by insurance companies and filing of insurance forms are the patient's responsibility.

A fee of $50 will be charged for cancelled appointments with less than 24 hours notice.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore for said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay all costs of collection and attorney fees of thirty-three and one-third percent of principal and inter-est amount owed on my account if my account is turned over to an attorney for collection.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and my account. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, Parent or Guardian