Peter J Adams DDS
Family Dentistry

502 Bud Drive Ste 102
Chesapeake, VA 23322
(757) 547-0222

FINANCIAL AND INSURANCE AGREEMENT

Thank you for choosing Dr. Peter Adams' dental office. Please read the following statement regarding our financial and insurance policies.

If you do not have dental insurance coverage, payment for the office visit, consultation, or any procedure is expected the day the service is provided.

If you have dental insurance, we will be happy to file your claim but please understand that insurance is an agreement between you and your insurance carrier, and that we are not a part of that agreement. Please also understand that we do not participate with all insurance providers. **At all times, you are responsible for the full amount of your bills, regardless of the status of the insurance claims.**

You are responsible to:

> **Verify with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.**
>
> **Pay our office for any deductible, co-payments or non-covered charges. If you pay by check and your check is returned for any reason, you will be charged a $35.00 processing fee by us, as well as whatever fees your bank assesses.**

We will file your claims with your insurance carrier as a courtesy to you, and accept direct payment from your insurance company. However, if we are not a participating provider with your insurance, and payment is directed to you, it is your responsibility to provide payment to our office. You will also be billed if we have not received any response from your insurance carrier after submitting claims. If you feel your insurance should have paid for a service, you should contact your insurance carrier for resolution. By signing this form, you authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on your behalf and will personally be active in the resolution of claims delay or unjustified reductions or denials.
We expect payment in full upon receipt of your bill. All accounts not paid in full within sixty (60) days of the date of service shall incur a financial charge in the amount of two percent per month (24% per annum) on the unpaid balance from the date of service. If this dental office refers this account for collections, the patient and/or responsible party shall be responsible for all costs of collections, including attorney's fees (33-1/3% of the amount referred for collection), court costs and any other associated collections costs.

Should you need to make payment arrangements, or have any questions regarding your bill, please call our office. We are more than willing to work with you to resolve your balance.

APPOINTMENT POLICY

As a courtesy to our valued patients, especially those who are waiting to schedule an appointment, we ask that all our patients make every effort to notify this office as soon as they discover that they cannot be present at their appointment. If a patient does not arrive for their scheduled appointment and does not give at least 48 hours notice that they cannot be present at their appointment, there will be a $50.00 non-refundable fee required to schedule another appointment. This $50.00 will be applied toward the fee for their next appointment. If the rescheduled appointment is also failed without 48 hours notice, the $50.00 fee will not be refunded.

We continue to strive to deliver the finest dental care possible in a friendly, professional environment. Thank you for supporting our practice and please know how much we value your loyalty.

____   ____________________
Signature of Patient/Parent/Guardian/Guarantor   Date

Home phone ______________________________

Work phone ______________________________

Cell phone ______________________________