Dental Care of Mclean
6711 Whittier Avenue, Suite 201
Mclean, VA 22101
(703)356-2020

Dental Care of Alexandria
1451 Belle Haven Road, Suite 430
Alexandria, VA 22307
(703)765-6400

FINANCIAL POLICY

Please initialize each paragraph –

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible to know your Plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits and limitations, such as a missing tooth clause, Cosmetic procedures, Cosmetic Orthodontics, TMJ/Sleep devices, downgraded restorations on molar teeth, frequency limits for exams, prophylaxis, fluoride, and x-rays, etc.
The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, American Express, Discover, or FSA or HSA cards. To help you accept an extensive treatment plan, we offer Care Credit. All estimates are subject to final approval by your dental insurance plan; therefore the amount due is subject to change after final explanation of benefits have been paid.
______(Initialize)

INITIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam and cleaning, no deductible is due for diagnostic or preventative treatment unless otherwise stated. There are some plans with coinsurance payment for x-rays and dental exam. Deductible for basic/major services customarily include fillings, crowns, extraction, root canal therapy, periodontal treatment.

- Deductible are usually ($50-$200 per individual)
- 20%-30% co-payment for all basic services
- 50%-60% for any major service build-up & crown procedure. Most Plans do not allow separate benefits for crown Build-up. In such a case the patient is responsible for the full cost of a build up
- SCRP (deep cleaning treatment) - the coinsurance rate for each quadrant due at the first appointment.

______(Initialize)

RESIN-BASED COMPOSITE RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment- AMALGAM (silver/mercury based restoration). The difference is usually $10-$70 per filling and the patient is responsible for the difference in cost. Please ask our front desk or doctors if you need more information about composite-based "white" fillings.

______(Initialize)

PULP-CAP TREATMENT (medicament to protect pulp chamber): Most dental plans do not allow additional benefits for pulp-cap treatment (this procedure in which the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing and repair via formation for secondary dentin).The cost of this treatment is $20- $53 per tooth (depends on your Insurance coverage) and the patient is responsible for payment at the time of treatment. If your Insurance does not cover it or does not allow separate benefits, you will be charged a contracted fee (between us as a provider and The Insurance)

______(Initialize)

FINANCIAL CHARGES: All returned checks are subject to a minimum $30.00 fee. All balances over 60 days are subject to interest in amount of 1.5 % per month mandated by State law. We reserve the right to apply a $25.00 late charge fee toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau.

______(Initialize)

PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.
______(Initialize)

MISSED APPOINTMENT FEE: Please note that you are subject to a missed appointment fee of $45.00 for all appointments not given at least 24 business hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment.

______(Initialize)

TRANSFERRING RECORDS: You will need to request in writing if you would like us to mail, fax, e-mail, etc. any part of your records. We need at least 7 working hours in advance to prepare your record to be transferred. We need at least 3 business days, if your record is more than three years old and is stored in a company's archive. There is a $25.00 fee for copying, scanning, or mailing your records. Currently we do not charge for your digital records. At any time we may extinguish this no charge policy and charge a fee for records and x-rays
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FINANCIAL POLICY

This is an Agreement between **John A. Schehl, D.D.S., P.C.** as a provider of professional services and creditor, and the patient/debtor named on this form. By reading and signing this Agreement, you are agreeing and accepting this Policy in full.
I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF DR. JOHN A. SCHEHL, D.D.S., P.C.

PRINT NAME ______________________________________ (PATIENT/SUBSCRIBER, if minor-GUARDIAN)

SIGNATURE ____ **DATE** __________________________

PHOTO AND DIGITAL IMAGES CONSENT FORM

Dr. John A. Schehl, D.D.S., P.C. and staff, may keep on file a copy of each individuals digital x-rays, intraoral exam photos, and Head/Face/neck pictures. These documents may be used for educational purposes to teach other patients or doctors, Insurance, liability, and website advertising. The patient will always remain anonymous when using films for any purpose (except insurance-see privacy practice form). By signing this consent I agree that Dr. John A. Schehl, D.D.S., P.C., Associate Providers, & staff have my permission to use all photos, intraoral images, and x-rays of me at any time at no cost. I may revoke the use of my images, digital x-rays, intraoral images at anytime by contacting John A. Schehl, D.D.S., P.C.

Signature__________________________________ **Date** _________________

DENTAL INSURANCE CLAIM PROCESSING POLICY

Because dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role.
It is your dentist's responsibility to recommend what you need. All recommendations are based on diagnostic (x-rays) and clinical picture and presented to you by your dentist or by the office manager. Your dentist will give you options (if any) for the treatment recommended, will answer all questions you might have about it and will help you to decide what treatment would be the best for you.
When you office visit is completed, the receptionist will enter the charges into the computer. You will be asked to pay an estimated amount for the service provided. Our estimate is a guess based on the information provided by the insurance representative over the phone. The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.
If you carry a supplementary or secondary Insurance Plan, we will help you with both Insurance claims, but we still will follow our Policy to collect deductible, coinsurance, pre-payment. Your overpayment, if any, will be returned back to you after secondary claim will be cleared, in the form of original payment
______(Initialize)

If you are interested in following the doctor's recommendation and need to know exactly how much your Insurance plan will pay for it, a pre-treatment estimate will need to be filed. We will file a patient treatment pre-estimate to their primary insurance upon the patient's request before the treatment is begun.
______(Initialize)

We will send a dental claim on your behalf and we will answer any questions your Insurance Company may raise about diagnosis or treatment in an appropriate, timely manner. It is important that you understand we are not part of the relations between you and your Insurance. If insurance denies benefits for patient's treatment for any reason, the patient is financially responsible for all charges and for outstanding balance on the account. We are unable to "force" an insurance company to fulfill its obligations to you.
If the insurance company does not pay for your treatment in a reasonable period of time (more than 2 months) patient is responsible to pay the balance off. All credits if any will be returned to the patient upon receiving final payment from the insurance
______(Initialize)

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED.

PRINT NAME ______________________________ (PATIENT/SUBSCRIBER, if minor - a GUARDIAN

SIGNATURE ____________________________________ **DATE** ______________