EVA M. PLETA, D.D.S.
8308C Old Courthouse Rd., Vienna, VA 22182
(703) 893-1100

OFFICE FINANCIAL RESPONSIBILTY

To help us serve you better, please read the following financial responsibility:

Payment in full is due at the time of service unless a previous arrangement is made. We accept personal checks, cash, VISA, MASTERCARD.

*There is a **$35 return check charge** each time a check is returned for any reason. Your appointment time is reserved exclusively for you. We require a 24 hour notice for all cancellations. There is a **$25 charge** for a missed appointment without a 24 hour notice.*

As your dental care provider it is our responsibility to provide you and your family with the best possible dental care. Please remember, your insurance policy is between you and your company, and not between the insurance company and Eva Pleta, D.D.S.

For our insured patients: As a courtesy, we file your insurance claim from this office. Any difference between charges for services and insurance payment will be payable by you, the patient.

- *Plan benefits are complex and unique for each subscriber. As the subscriber, you are responsible to know your unique benefits, coverage, deductibles and limitations. Failing to do so will result in, you the patient, being responsible for all the costs incurred.*

- *It is your responsibility to provide us with your current insurance information to ensure that your claim will be processed effectively. Please notify the front office of any changes of insurance information since your last visit. Filing insurance claims from this office is a courtesy to you the patient.*

- *Billing statements for balance due are payable up receipt in full. Balances 30 days past due are subject to a **$10 monthly rebilling fee** and a **1.5% monthly finance fee**, unless you have made other financial arrangements with this office. If your account is turned over to our attorney or collection agency after 60 days, you agree to pay all collections fees including court costs and added interest from the initial statement date.*

If there is anything we can do to make your visit more enjoyable, please feel free to let us know. We are committed to providing you excellent dental care and to your family. Your signature indicates that you have read, understood and agreed to all of the above policies. As a responsible party, your signature indicates acceptance of the above mentioned policies and authorizations. Thank you.

Patient Name: _____ Date: _____
Patient/Guardian Signature: _____