Endodontic Associates of Greater Washington

Ian K Walker DDS | Yaser F Roumani DDS
Chetan Yelamanchi DDS | Christopher Jin DMD

Financial Policy

PATIENT INFORMATION

First Name		Last Name		Birth Date	

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy so that we can minimize our billing cost.

All patients must complete our Office Health History and Financial Policy in its entirety prior to being seen by the doctor

Payment is expected at time of service, unless other arrangements have been made, prior to treatment.

INSURANCE

The patient (or responsible party) is responsible to pay any deductible and percentage due **AT THE TIME OF SERVICE**. The percentage quoted you is **an estimate** and not a guarantee of payment from your insurance company. In order for us to file claims in your behalf, you must supply us with all necessary insurance information. Please refer to your insurance manual for specific coverage. Your insurance policy is a contract between you and your insurance company. If your account has not been paid within 45 days, ***the balance will be due in full by you, regardless of insurance status.***

- ❑ For the plans which we are a participating provider, we will submit the claim for you.
- ❑ For the plans which we are NOT a participating provider, if your insurance company accepts electronic claims, we will, as a courtesy, submit the claim to your insurance carrier. If an overpayment occurs, we will refund you that payment within 7-10 business days.
- ❑ If your insurance company does not accept electronic claims, you will be responsible for all charges **AT THE TIME OF SERVICE**. We will provide you with a coded description of treatment rendered for **you** to file for reimbursement.
- ❑ Patient presented without proof of insurance.

MINOR PATIENTS

Unaccompanied minors will **not** be seen without written permission from a parent or guardian. The parent, guardian or adult accompanying a minor is responsible for full payment, their deductible, or percentage, **AT THE TIME OF SERVICE**. For unaccompanied minors, non-emergency treatment will be denied unless charges have been prepaid or the minor comes prepared **AT THE TIME OF SERVICE**.

FINANCE CHARGES

Any account balance carried over 45 days will be subject to a $15.00 billing fee, or a 1.5% interest fee per month, whichever is greater. In the event the account is turned over to a collection agency, the patient or responsible party shall be liable for any clerical, legal, and collection fees incurred, up to 30% of the outstanding balance.

NOTE: Balances sent to a collection agency will be billed at our usual and customary fee.

ACCEPTABLE METHODS OF PAYMENT

Please select the method of payment or co-payment that you will use today:

❑ Personal Checks* ❑ Cash ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

*Checks returned from the bank will be subject to a service fee of $35.00.

APPOINTMENTS

A fee of $90.00 per half hour may be charged for any appointment cancelled without 48 hour notice.

FORM COMPLETION

I understand and agree to this Financial Policy.

Signature of Patient, Parent or Guardian		Date	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	