FINANCIAL POLICY

Smiles By Mia
Dr. Mia Pham
8989 Fern Park Drive
Burke, VA 22015

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.

METHODS OF PAYMENT

1. Cash, Check, or Credit Card
2. Dental Insurance (described below)
3. CareCredit (3rd party financing)

Payment is required when services are rendered unless prior financial arrangements have been made.

DENTAL INSURANCE (where applicable)

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a courtesy to our patients, we will bill insurance companies for services rendered. If you have any questions, our staff is always available to answer them.

RELATED INFORMATION

1. For returned checks, a charge of $35.00 will be applied per incident, and balances older than 60 days may be subject to additional interest charges. These additional fees will be applied to the unpaid balance at the end of the month. Interest rates will be assessed at a rate of 1.9% per month or 19% annually.
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for the collection of your bill (i.e., attorney fees, court fees, and collection agency fees).
3. We reserve the right to charge $50.00 *(per Hour)* for appointments cancelled or broken without 48 business hours of notice. This fee covers only a portion of the overhead such as salaries, electric, heat, etc.

Once an appointment has been made, please remember that this time has been reserved exclusively for you.

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered. I agree to be responsible for any charges not paid by my dental plan. I understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest at 1.9% per month (19% per annum), and all court costs.

PATIENT NAME (Please Print): _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____