Merrifield Dental Partners
Dany A. Barakat, D.D.S., P.C.

Thank you for choosing our office for your dental care. We are committed to the success of your treatment.

Our Fees:

Your co pay and deductible are due at the time of service. To accommodate you; we accept cash, checks, Visa, Master Card and Discover. For extensive treatment plans, we offer extended payment plans with prior credit approval. If your account is sent to a collection agency, you will be responsible for any and all costs involved with the collections process including court costs and attorney fees.

Please keep in mind that accounts are due upon receipt of the statement unless prior financial arrangements have been made. A service charge of 2% per month will be charged on all past due amounts. This is an annual percentage rate of 24%. A minimum finance charge of $5.00 per month will be charged on all past due accounts.

Regarding Insurance:

At the time of service, your **full co-payment and deductible** are due. We will gladly submit the primary claim on your behalf and provide you with the necessary paperwork to file your secondary claim. It is your responsibility to inform us of any changes to your insurance plan or coverage. Because all insurance calculations are **estimated**, sometimes some or all of the services provided may **not** be covered under your plan. If services are **not** covered, please note that the full financial responsibility is yours. If your claim **has not been paid** by your insurance within **45 days**, the balance becomes your responsibility and we will send you a statement by mail.

Missed Appointments:

Please consider your calendar carefully when scheduling an appointment. Missed appointments and cancellations with less than **24 business hours** notice will be charged a $50 broken appointment fee. We appreciate your cooperation because providing a notice of **at least 24 business hours** will allow us to accommodate another patient waiting for treatment. We understand your time is valuable and will do our best to remain on schedule.

Your signature below indicates that you have read and agree to our financial policy. Thank you for being our valued patient.

Signature_____ Date_____

Print name_____