WAY FAMILY DENTISTRY
DR JORGE WAY, DDS
OFFICAL FINANCIAL POLICY

Kindly review carefully and sign the office policy.

1. **INSURANCE POLICY:**
   We accept most insurance plans and will file your insurance claim, payable to "Way Family Dentistry or Dr. Jorge Way", for the services rendered. Please understand that your dental insurance is your responsibility. **We try to provide the service of verifying your eligibility, submitting your claims, and estimating your co-pay.** It is important that you the patient, know, and understand your dental coverage & co-pays by contacting your dental insurance company. If your insurance plan changes, it is your responsibility to inform the office immediately.
2. TYPES OF PAYMENT ACCEPTED
   - CASH & CHECKS ($40 fees charged for returned checks)
   - CREDIT CARDS: VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER.
3. We required PAYMENT IN FULL FOR YOUR ESTIMATED PORTION AT THE TIME OF TREATMENT. If you are unable to pay in full, please let us know **before** any treatment is done.
4. SCHEDULING AND CANCELLATION:
   Appointments that you make are reserved solely for YOU AND THE DOCTOR. Please give our office consideration to fill your reserved time slot if you need to cancel or reschedule your appointment. Allow our office at least **48 business hours** advance notice to cancel or reschedule. Please note that FRIDAY, SATURDAY AND SUNDAY DO NOT COUNT AS BUSINESS DAYS. **Any cancellation notice that is less than 48 business hours will be subject to a $50 broken appointment fee per half hour.**
   If your appointment is not confirmed within 48 business hours, we can give away your appointment slot. **If your are late by 15 minutes or more,** your appointment can be considered broken and a cancellation fee of $50 per half hour can be charged.
5. **FINANCIAL AGREEMENT**:
   "To the best of my knowledge the information I have provided to this office is complete and accurate. I understand and accept that all charges incurred for my treatment in this office are my responsibility. **Should my insurance company for any reason fail to pay for any or all charges billed, I agree to pay for these services upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of 60 days,** it may be referred to an 'Attorney or Collection Agency' and that I further agree to be responsible to pay for all costs incurred in this connection, including attorney fees or collection agency fees and any additional interest on the balance due amount at the rate of 18% per annum. **If we are unable to verify your insurance coverage, then you will be responsible for the payment in full at the time services are rendered."**
6. DUPLICATION OF RECORDS
   In the event that your records need to be transferred out of office for any reason other than a referral, there will be a **$25 Administrative Fee** for Release of Records / X-rays. Even after transfer of records out of our office, we are required to keep your records on file for a period of 7 years and hence the above mentioned fees are charged to cover the expenses.
   I HAVE READ AND AGREE TO THE ABOVE FINANCIAL POLICIES.

_____ _____
Signature Date

Name of Patient:_____ **(TURN PAGE)**

(OPTIONAL)

AUTHORIZATION TO CHARGE MY CREDIT CARD:

By signing below I authorize Dr. Jorge Way and Way Family Dentistry to charge my credit card which is listed below for payment plans, all outstanding balances and for any claims denied or not paid by insurance company within 60 days.

_____ _____

Print Patient Name Print Cardholder Name

_____ _____ _____ _____

Credit Card Number Type of Card Expiration Security Code (CVV #)

_____

Billing Address for the above Credit Card Account

_____

Signature of Guarantor/Guardian

WAY FAMILY DENTISTRY
DR JORGE WAY, DDS
11166 FAIRFAX BLVD. #306, FAIRFAX, VA 22030
TEL: 703-691-3015 FAX #: 703-691-3016