CEDAR CREEK DENTAL

Dr. Alexis Mierzwa, DDS & Dr. Hassan Farooq, DDS
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PH: 540-486-5111

Office Policies

Assignment and Release

I the undersigned, have insurance with _____, and assign directly Cedar Creek Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____

Signature of patient/parent/legal guardian

Print Name:_____

Print name of patient/parent/legal guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Cedar Creek Dental and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that I have a contract with my insurance company, and that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s) of all services rendered. I understand that if payment for services is denied by my insurance company for any reason, I may request an appeal for services denied, but that I am required to pay the balance for the costs incurred immediately, as the appeal process may take an extended period of time to resolve. Cedar Creek Dental will aid in the appeal process to their full capability, and will reimburse me immediately if my insurance company reconciles the claim appeal.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 2-business days prior to my scheduled appointment time. ***I will be required to make a reservation fee of $75 for any appointment(s) 90 minutes or longer, which will require a reservation fee of $75 per hour scheduled. This will be paid at the time of scheduling the appointment(s), and will be applied to my out-of-pocket expense for the appointment when I keep it. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

For patients that do not have dental insurance, we offer you 5% cash or check discount ONLY if the entire treatment plan is paid for up front, not by phase or appointment. In additional, we offer Care Credit, a patient payment program offering a full range of deferred interest and extended payment plans for treatment. Payment for services is due at the time services are rendered. Checks that are returned to our office from your financial institution are subject to a $50.00 returned check fee. This fee covers the processing fee that the bank charges to our office. We realize that temporary financial situations may affect timely payment on your account. If such situations do arise, we encourage you to contact us promptly so that we may help you in the management of your account.

Failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____

Signature of patient/parent/legal guardian

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____

Signature of patient/parent/legal guardian