James O. Glaser, DDS. P.C.
IRONBRIDGE FAMILY AND COSMETIC DENTISTRY
9510 IRONBRIDGE ROAD, SUITE 100
CHESTERFIELD, VIRGINIA 23832

Financial Agreement

Patients Without Insurance: Payment in full is expected at the time of service. In case of extensive treatment, financial arrangements must be made with the front office personnel, prior to the treatment or therapy being given.**

Patients With Dental Insurance: We are happy to file your services with your insurance company as a courtesy for you. We do not accept responsibility for following up on or re-filing insurance claims, which have been denied. You are responsible for any charges that are incurred in this office regardless of coverage or not. Please be prepared to pay your co-pay or percentage at the time of service. You are also responsible for any uncovered service that is rendered and for all differences not paid by your carrier.

AUTHORIZATION AND RELEASE:
To the best of my knowledge, the questions on these forms have been answered accurately. I understand that providing incorrect information can be dangerous to myself and/or my child's health. It is my responsibility to inform the dental office of any changes in my or my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentist or the dentist group insurance benefits other wise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

In the event that your personal balance is not paid within 30 days of the charge, interest charges/ finance charges will be added to the balance owed. The monthly rate is 1 ½%. The annual percentage rate is 18%. This will apply to all accounts regardless of whether you have insurance or not.

***** For all minor children brought into this office for treatment, we consider both parents to be financially responsible for all costs incurred in treating your child regardless of which parent brings the child to this office. We will bill the parent that brings the child into the office. We will not bill the other parent in cases of divorce.**

***** There will be a minimum charge of $25.00 per ½ hour for all appointments, which are cancelled without 24 hours notice. The maximum charge will be $50.00 per ½ hour. The rate will be determined according to the length of the appointment that is missed.**

____ **DATE** ____________________
Signature of Patient or Responsible Party if minor:

The Following are accepted forms of Payment in our office:
Cash, Check, Money Order, American Express, Discover, MasterCard and Visa

****We also offer financing through CareCredit or CapitalOne Healthcare.**