Cornerstone Dental
2 Cardinal Park Drive, Suite 206-A Leesburg, VA 20175
Phone (703) 771-3389 Fax (703) 771-8242

Thank you for choosing our office as your dental health care provider. We are committed to the success of your treatment. Part of the commitment is your understanding and responsibility for the payment of your account balance.

FINANCIAL POLICY PATIENTS PORTION OF ACCOUNT PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECK, MONEY ORDER, VISA/MASTERCARD, AND DISCOVER. We offer special financing through Care Credit and Citi Card for those patients who need extended payment options. Please note: all payment arrangements must be finalized before treatment begins.

ADULT PATIENTS

Adult patients are responsible for patient's portion of account payment at the time of service unless specific arrangements are made prior to the start of treatment.

MINOR PATIENTS

The adult accompanying a minor or parents/guardians are responsible for patient's portion of payment at time of service.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

Please be aware that some and perhaps all of the services provided may not be covered services. You are ultimately responsible for the entire balance no matter what the outcome is with your insurance provider.

Initial_____

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, we are proud of our fees, which are considered usual and customary for our local area.

Patient/Guardian is responsible for full payment for services rendered regardless of any insurance company's arbitrary determination of usual and customary rates. As a courtesy to our patients, we file all standard documentation to your insurance company to assist in acquiring the maximum benefits available for our patients under their contracted insurance plan.

PATIENT RESPONSIBLTY AND ADDITIONAL TERMS

Delinquent accounts over 60 days from day of service are subject to a late fee of $30.00, a financial charge of 1.5% monthly (18% Annually) on remaining account balance, and the account will be forwarded to a collection agency. Please note that additional charges maybe incurred by the patient including court costs and reasonable attorney's fees.

MISSED APPOINTMENTS

We require 24 hours cancelation notice in advanced of any scheduled appointment. A **NON-RFUNDABLE** fee of $75.00 will be applied to your account for any missed appointment.

We would be happy to discuss any questions or concerns you have regarding this financial policy. Thank you for your understanding and cooperation.

I have read, understand and agree to the terms of the Financial Policy stated above.

X _____ Date_____
Signature of Patient or Parent of Minor Patient

Cornerstone Dental

Sue K. Moon, DDS

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Leesburg, Virginia 20175
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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, understand and been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Signature: _____

Print Name: _____

Relationship to Patient: _____

Date: _____