

Drs. WOODSIDE & SENTZ
Cosmetic, Implant & General Dentistry

361 WALKER DRIVE, SUITE 204
WARRENTON, VA 20186
(540) 341-4111

FINANCIAL OBLIGATIONS

METHODS OF PAYMENT: Cash, Check, VISA, MasterCard, Discover / Care Credit or Money Order

RELATED INFORMATION:

1. Your appointment time has been reserved exclusively for you and any changes in your appointment affects many patients. To avoid a missed or broken appointment charge of \$57.00, please contact our office 24 hours prior to your appointment when a change or cancellation is necessary. Not receiving a confirmation call from our office does not indicate that there has been a change in your scheduled appointment or the office schedule. You are asked to contact our office if you have any questions or concerns about your appointment.
2. A \$30.00 fee will be charged for any check returned by your bank. Subsequently, you have ten (10) days to make payment on that check or your balance will be sent to collections. Should your bank return two (2) checks you will only be able to pay by cash, money order or credit card for all future appointments.
3. Our office generates statements at the end of each month. Each statement will show whether there is any outstanding insurance that we are waiting on along with any balance due on your part. At that time you are responsible for payment in full on your account. Should your account go 60 days overdue a letter from our office will be sent to you. After 90 days with no response or payment from you, your account will be turned over to collections at which time you are responsible for all collection fees (i.e. attorney fees, court costs, etc.).
4. All unpaid balances are subject to interest charges.
5. If you do not have dental insurance, payment in full is expected at time services are rendered.

DENTAL INSURANCE:

1. We are pleased you have dental insurance. However, your insurance contract is between You, Your Employer and the Insurance Company. The insurance company may pay all, some or none of your treatment. Not all necessary services are a covered benefit under all contracts. Therefore, you are responsible for the total amount regardless of insurance reimbursement.
2. A copy of your current insurance card is required at the time services are rendered. We will use the dental information you provide us to print your claim with the current ADA (American Dental Association) codes and submit to your insurance company as a courtesy to you. Please note that we must have the name of the insurance company, subscriber identification number, mailing address, group number and telephone number for each appointment. We work with many dental plans and do not know the specifics of your plan. Please verify your information with your insurance company, benefits coordinator or human resources department prior to your appointment so that an accurate insurance claim can be processed and payment received in a timely manner.
3. Our office participates exclusively with the **Delta Dental Premier, United Concordia and Dentemax Insurances**. We will file your dental claim with all other insurance companies, however, you are responsible for the full balance after your insurance payment is received.
4. By signing this contract you are allowing the release of all information to your insurance company to process your claim(s) and authorizing your insurance company to pay benefits directly to Dr. Thomas C. Sentz and Dr. Jason S. Woodside
5. I acknowledge that, upon my request, I may receive a copy of this financial obligation agreement.

I have read and understand the above information. I understand that I am Ultimately responsible (regardless of my insurance) for any charges incurred from services rendered and for payment of all charges.

NAME (please print) _____

SIGNATURE _____ **DATE** _____