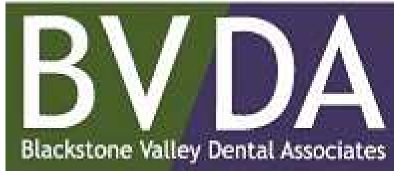

FINANCIAL POLICIES

Thank you for choosing Blackstone Valley Dental Associates. In an effort to better serve you, we would like to take the time to explain our billing process

Payment is expected the day services are rendered. For patients with dental insurance, if you provide the office with your dental insurance information, we will contact your issuance company and verify your benefits. We will do our best to work with your insurance and inform you of your insurance coverage but we do ask that you keep our office informed of any changes in your policy.

As a courtesy to you, we will gladly submit the insurance claim to your insurance company o the day of service. We will collect your estimated co-payment and deductible at each visit. We make ever effort to determine your insurance benefits when you receive treatment, but consider you co-payment an estimate until we receive payment from your insurance company. Please remember that any information we provide relative to your coverage is our best estimate and not a guarantee of payment that will be received.

In order to provide quality dental care in a timely manner, we have a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need or dental care.

CANCELLATION OF AN APPOINTMENT:
In order to be respectful of our patients' needs, please be courteous and call our office promptly if you are unable to keep your appointment. This time will be give to someone who is in urgent need of treatment. We will ask that you make an attempt to call the office directly 24 hours I advance (no texts and emails).

NO SHOW POLICY:
A "no show" is an appointment that was not canceled in advance. No shows inconvenience other patients who need dental care. A no show for a schedule appointment is subject to a minimum fee of $50.00.

LATE ARRIVALS
If you are running late for your appointment, please call the office. If you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule.

I HAVE READ AND UNDERSTAND THE APPOINTMENT POLICY AND BILLING PROCESS AT BVDA. I AGREE TO BE RESPONSIBLE FOR FULL PAYMETMENT OF ALL CHARGES FOR DENTAL SERVICES PERFORMED ON ME. I ASSIGN ALL BENEFIS TO THE PRACTICE AND IF FOR ANY REASON THE INSURANCE COMPANY DOES NOT PAY ITS ESTIMATED PORTION, I AGREE THAT I WILL BE RESPONSIBLE FOT THE ACCOUNT BALANCE. IN THE EVENT MY ACCOUNT IS PLACED WITH A THIRD PARTY COLLECTION AGENCY OR ATTORNEY, I WILL BE ASSESSED ANY FEES RELATING TO THIS ACTION.

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PATIENT'S NAME (PRINT)

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PATIENT, GUARDIAN OR PARENT'S SINGNATURE

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DATE SIGNED