DAMASCUS DENTAL
GROUP

9701 NEW CHURCH STREET, SUITE 9
DAMASCUS, MD 20872
(301) 253-2174

Thank you for choosing our practice!!! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing dental care services to our patients.

We participate with most PPO insurance plans. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits.

The following are our financial guidelines relative to financial responsibility:

- Payment is expected at the time of service. This includes co-pays, co-insurance, and deductibles.
- Please provide a copy of your insurance card at each visit
- It is our policy not to extend professional courtesy discounts.
- For our self pay patients (patients who have no insurance coverage), we offer a 10% discount for professional services paid in full on the date of service. This does not apply to co-pays, co insurance, deductibles, noncovered services and dental supplies.
- You may be charged a $50.00 no-show fee for any appointment missed, not cancelled/rescheduled with a 24 hour notice.
- Accounts may be turned over to a collection agency if past due 90 days or more
- A service charge of $30.00 will be added for returned checks
- A service charge of $10.00 will be added for co-payments not received on the date of service.
- Patients are legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collection proceedings on any unpaid balance.

We appreciate the opportunity to participate in your family's dental health. If you have any questions regarding this policy, please let us know.

I have read, understand and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

_____	_____	_____
Printed name	Signature	Date