FINANCIAL POLICY

Payment is expected at the time of service. For your convenience we offer several payment options including cash, check, debit card (w/ Visa or Master Card logo), credit card and CareCredit.

If you are using Dental Insurance to help with payment, your co-pay will be due at the time of service. We will be happy to file your claim for you; however, your bill is ultimately your responsibility should insurance not cover the expected amount due.

For alternative payment arrangements we require that a valid credit card be held on file. Should you fail to meet your obligation, we may process your credit card for any outstanding balances. We will never charge your card without first calling to notify you of the outstanding balance.

This policy is necessary for us to maintain the level of services and care that all of our patients expect of us. If you have any questions about our financial policy, please feel free to contact our Financial Administrator at your convenience.

Credit Card Type (circle one): Visa Master Card American Express Discover CareCredit

Card Number: ____

Expiration Date: _______/___________

CVV code: ___________

Card Holder's Name: ______________________________________

I authorize Tidewater Dental and Associates to process any outstanding balances on my account to the credit card listed above.

____ ______________________
Signature Date

____ ______________________
Print Name Date

BROKEN APPOINTMENT POLICY

Tidewater Dental knows your time is valuable, and we respect that! In fact, we make it a point to schedule all of our patients with this in mind. Our daily goal is to seat all of our patients on time. In an effort to provide timely service to our patients we never over-book our schedule like so many other health care facilities. This makes our time very valuable to us as well. Therefore, in an effort to avoid broken appointments and late patient arrivals, the following policy has been adopted:

1. All cancellations or rescheduled appointments must be arranged two business days prior to appointment date.
2. Patients arriving more than ten minutes late may be rescheduled at Tidewater Dental's discretion.
3. Patients who...
   - don't show up for their appointment, or
   - reschedule without two business daysqnotice

   ...will be charged a $50.00 missed appointment fee.

To avoid raising our dental fees and allow for all of our patients to reserve appointment times when desired, we find it necessary to implement this policy.

Thank you for understanding and respecting our time and policy. If you have any questions regarding this matter, please contact Jeff Tomcsik at 301-862-3900.

Signature: ____

TIDEWATER DENTAL PATIENT PROMISE

The success of your restorative dentistry requires a commitment from both of us. Tidewater Dental promises to use the best materials, equipment, techniques, and laboratories to bring your smile to its healthiest possible condition. We will manage your restorations done here, and assume responsibility for any repairs within the guidelines set forth by your dental insurance plan. In other words, if you get a crown done by Tidewater Dental, and your insurance states that it will not pay for another crown on that same tooth for five years, we will honor all repairs at no cost to you for that same amount of time provided you follow these simple and fair guidelines:

1. You agree to follow all hygiene protocols recommended by your dentist or hygienist
    a. Schedule and go to all recommended hygiene visits
    b. Follow all hygiene recommendation for preventative care, including home care.
2. Get all necessary restorative dentistry done in a timely manner as recommended by your dentist. (i.e. fillings, crowns, replacement of teeth to restore function, occlusal guards to prevent breakdown of teeth.)
3. Follow all care, maintenance, and preventative directions as prescribed by your Tidewater Dental team of professionals
4. Show up on time to all appointments and follow our broken appointment guidelines
5. Remain current on all balances due.

We believe in the dentistry we do. We stand behind it. But we can't control what you do after you leave our practice. We will do our part. If you do yours, we will honor all insurance based time limits for standard of care in regards to retreatment, replacement and repair to your dentistry. In return you must follow all of our restorative and preventative care guidelines and recommendations.

I understand Tidewater Dental's restorative care promise and will follow the rules set forth so that my dental treatments will be covered for repair and/or replacement. Should I not maintain my commitment to preventative care and maintained oral hygiene, I understand that Tidewater Dental will not be able to guarantee the longevity of any restorations done at Tidewater Dental.

____ ______________________

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I, ____, acknowledge that I have received a notice of privacy practices from Tidewater Dental.

Signature:____ Date:______/______/________

If a personal representative signs this authorization on behalf of the individual receiving treatment, complete the following:

Personal Representative's name: ____

Relationship to individual receiving treatment: ____