Lake Arbor Dental Associates
10274 Lake Arbor Way, Ste.203
Mitchellville, MD 20721

# Statement of Office Policy and Patient Responsibility

## APPOINTMENTS:

Once an appointment has been made, please remember that this time is reserved for you. There will be a minimum charge of $50.00 per hour scheduled, without a 24 hour notice. This fee covers only a portion of the overhead such as salaries, utilities, etc.

## INSURANCE:

To avoid misunderstandings regarding dental insurance, we want our patients to know any patient **co-payments are due when the services are rendered.**

As an accommodation to you, we will prepare the necessary forms or reports to assist you in obtaining your benefits from insurance companies. We will attempt to the best of our ability to **estimate the co-payment** portion of your benefits. **Please remember that this is just an estimate and the actual amount of your co-payment may be slightly higher or lower than the original estimate once the insurance has process and paid the claim.**

It is the patient's responsibility to know their insurance and their benefits such as frequencies and limitations. As a courtesy LADA will attempt to obtain the benefits from the insurance with the information the patients provides. Any changes of insurance or if there are any changes in the policy you must notify the front desk. The patient is responsible to pay for the services not covered by your insurance or the difference if your insurance has downgraded services rendered.

## PATIENTS LEAVING THE PRACTICE:

In the event a patient decides to transfer dental records to another facility, the balance of the account must be paid in full and a record release form must be sign. There is a $25.00 record duplication fee. The record will include x-rays taken in the past 12months (with the exception of panoramic film), perio charting, and initial evaluation.

## COLLECTIONS:

After 90 days all delinquent accounts may be referred to our collection agency and patient, guardian. or Insurance subscriber of the account will be responsible for reasonable collection fees, court costs and attorney fees involved in the collection amount.

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**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY,** **DATE**