



MT DENTAL PARTNERS

WASHINGTON, DC • ALEXANDRIA, VA

OFFICE AND FINANCIAL POLICIES

PAYMENTS

Payment is required at time of service. We accept payments via checks and all major credit cards including Visa, MasterCard, Discover and American Express.

INSURANCE

We believe it is important for us to work with our patients to determine their clinical needs rather than have them dictated by a 3rd party. Thus, we are a fee for service practice and are neither contracted with nor accept direct payment from any insurance company. Patients who have dental benefits are responsible for confirming coverage with their respective insurance company prior to any dental treatment. Patients who have insurance will be provided with the appropriate form(s) that they may file for any reimbursement.

PAST DUE ACCOUNTS

All accounts past 90 days will be considered past due and are subject to an accrued interest of 18% . Past due accounts may be sent to a third-party collection agency and all fees from the Practice and the collection agency will be provided to the patient.

RESCHEDULING & CANCELLATION POLICY

Your appointment is a reservation of time in our office just for you. Cancellations or rescheduling with less than 48 hours notice prevents us from filling your vacancy. Be advised **any** reservation adjustments within that window will result in a per hour fee of \$525 for doctor time or \$219 for hygienist time.

If you arrive more than 15 minutes late for your appointment, it may be considered a missed appointment and you will need to reschedule. You will be responsible for the reschedule fee. If you arrive less than 15 minutes after your appointment time, it will be at the discretion of your provider to determine if all of your treatment can be completed and whether you will need to reschedule.

RADIOGRAPHS

Since we know that dental diseases, such as cavities and periodontal diseases, can progress without clinical symptoms, radiographs provide a way to intercept problems before they become extensive and painful. At MT Dental Partners, our standard of care adheres to the guidelines outlined by the American Dental Association (ADA) to optimize patient care, minimize radiation exposure, and responsibly allocate health resources. The frequency with which we update x-rays is determined by these guidelines and individual patient risk factors. Our doctors will notify you of the necessary frequency based upon your individual risk factors. If you are unable to adhere to such guidelines and our standard, we will be unable to continue your routine dental care, including exams and cleanings.

EXAMS

MT Dental Partners requires a patient exam to be conducted every 8 months. Therefore, patients who are recommended to have cleanings every 3, 4, or 6 months will be scheduled may not receive an exam at every visit.

PHOTOGRAPHY

This document gives MT Dental Partners and the doctors within the practice the rights and unrestricted permission concerning any photographs they have taken or make of me for illustrations, promotional material, publication and generally as they deem appropriate within the scope of dentistry. If you do not consent to the photography release, please notify our staff.

CLINICAL CONSENTS

Responsibility of cosmetic and Invisalign treatment will be transferred from our office to our patients after signing of acceptable completion release. Invisalign procedures will be subject to our compliance policy.

Patients who wear appliances such as night guards, retainers, antisnoring, or sleep apnea treating devices are responsible for their replacement if, after treatment(s), existing devices cannot be retrofitted.

REFERRALS TO SPECIALISTS

In some cases, we may need to refer you to one of our specialists. Our patient concierge will assist you with reserving an appointment with the specialists' office and share all required information prior to your reservation. Please note specialists' fees are separate from ours.

WELCOME TO MT DENTAL PARTNERS

HERE TO REALLY GET TO KNOW YOU. AND YOUR SMILE.

I have read and I understand the Financial and Operating Policies of MT Dental Partners. I agree to be responsible for all dental services at time of service.

Patient Name

Signature of Patient/Parent/Guardian if Minor

Date