Gloria E. Ward, D.D.S., M.S., M.I.S., P.C.

3701 Westerre Parkway, Suite D
Richmond, VA 23233

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment for services performed is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. Also, all patients must complete our information form before seeing the doctor.

Full Payment is Due at Time of Service
We Accept Cash, Checks, Visa, MasterCard or CareCredit.

REGARDING INSURANCE
Insurance is a contract between you and your insurance company. We are not a party to that contract. We are not a participating provider for any dental or medical insurance company due to the nature of our practice. We will be happy to provide you with the necessary documentation that will enable you to submit for any reimbursement that you are entitled to.

USUAL AND CUSTOMARY
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We are glad to provide a copy of our payment options if you deem it necessary.

MINOR PATIENTS
The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

HOMESTEAD ACT
We are not a party to divorce decrees. Adult patients are responsible for their bill on the date of initial treatment. In the case of a minor patient, the accompanying adult must pay the bill. We are not a party to bankruptcy claims filed.

MISSED APPOINTMENTS
Unless cancelled at least 2 working days in advanced, we consider it to be a broken appointment and we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

FINANCE CHARGE
A finance charge will be imposed on your account if a balance has not been paid within thirty (30) days. This will be computed at the rate of one percent (l %) each month with the annual rate of twelve (12%) percent.

RETURNED CHECKS
There is a bank fee of $40.00 for any check returned by the bank. There will also be a handling fee of $25.00 for any returned checks.

I promise to pay my account promptly when due and if my account is referred to a collection agency or attorney for collection, that I agree to pay all costs of collection and expenses including, but not limited to any collection agency and/or attorney fees of not less that 25% plus court costs, whichever is applicable. I agree that failure to meet payment terms may result in a credit blemish on my permanent credit report. I waive the benefit of the homestead exemption. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read, understand, and agree to this Financial Policy.

Signature of Patient/Responsible Party **Date**

Witness **Date**