Michael S. Schroer, D.D.S.
(757) 221-0249

OUR OFFICE POLICY

Thank you for choosing us as your dental provider. We are committed to providing you with the highest quality of dental care. The following is a statement of our Office Policy that we require you to read and sign prior to any treatment.

FINANCIAL

Please understand that payment of your bill is considered a part of your treatment. We do our best to provide our patient with accurate costs pertaining to their treatment. However, all treatment plans given are an estimate. At times, unanticipated procedures may arise during a procedure that can not be avoided in order to complete treatment. Although this is not common, if this does occur, any additional cost would be due in full from you as the patient/guarantor.

•ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

•WE ACCEPT PAYMENT BY CASH, CHECK, VISA, MASTERCARD, DISCOVER AND CARE CREDIT. No in-house financing is provided. If you prefer to make monthly payments, we offer financing using Care Credit with prior credit approval.

It is the policy of Dr. Schroer to file insurance claims as a courtesy to the patient. The agreement of the insurance company to pay for dental care is a contract between the patient and insurance company. The financial responsibility for services rendered rests solely with the patient/guarantor. **Verification of your insurance coverage is not a guarantee of benefits. Benefits will be determined by your insurance carrier at the time a claim is submitted and acknowledged. It is the patient/guarantor's responsibility to pay for any non-covered services, deductibles, co-payments or any other balance not paid by the insurance company.** If your insurance company has not paid your account within 45 days, the balance will be due in full from you.

There will be a $35.00 fee for all returned checks, and if this occurs, you will be required to pay by cash or credit card for all future payments. I assign all benefits to Michael S. Schroer, D.D.S., PLC, and I understand that in the unlikely event collection is necessary, I am responsible for all collection, attorney and interest fees charged to my account in addition to the existing balance. As a patient/guarantor of this office located in Williamsburg, VA, I also consent to jurisdiction and venue in Virginia and this agreement being interpreted and enforced under the laws of Virginia.

APPOINTMENTS

Your appointments are a part of your treatment also. . Please help us better serve you by keeping scheduled appointments. It is your responsibility as the patient/guarantor to make and keep all appointments to ensure the success of your treatment and avoid additional fees. If you need to cancel or reschedule an appointment, we require a minimum of 24 hours notice. If you cancel or reschedule your appointment more than one time without proper notice, you will be required to pay in advance before rescheduling will be permitted

I have read, understand and agree to this Office Policy.

_____ _____

Signature of Patient/Guarantor *Date*