Advances in Dental Care
11904-A Darnestown Road
North Potomac, MD 20878
301-519-3455

Financial Policy

Fees:
All fees for services planned are usually discussed in advance when the cost is expected to be substantial and the treatment plan is complicated. Fees are usually not discussed when necessary services are limited or the planned procedures are routine (cleaning, fillings, etc.). If you have a concern regarding cost, or wish to know fees in advance, please feel free to speak to the office manager / receptionist. All fees are billed on the date the service is rendered or on the day the sequence of treatment is started.

Payment:
Payment in full is expected at the time of service or by such time as the service is completed or prosthetic device is fabricated and delivered. Whenever a prosthetic device is planned, 50% payment is required at the order/impression visit and the remainder is due before delivery of the prosthetic device (crown, bridge, and denture).
If you are not enrolled in an insurance plan you may pay for your dental services by cash, credit card (MC/VISA) or check. When you pay in full at the time of service and have no outstanding charges, you may be eligible for a five percent (5%) courtesy. If you are enrolled in an insurance plan in which we are participating providers, you must pay the co-insurance and any deductible at the time of service. We will submit the insurance forms to your plan and be reimbursed for the remainder of the fee. If there is any issue with under or over payment, we will notify for regarding the balance payable. If you are enrolled in an insurance plan in which we are not participating providers, you must pay our fee at the time of service. We will submit the insurance forms to your plan and you will be reimbursed by your insurance carrier.

Payment Responsibility:
Whether you have insurance or not, please remember the over-riding relationship resides between this office and you. We will plan and recommend treatment based upon your specific needs, not you insurance coverage. We treat people, not insurance plans. You are ultimately responsible for all costs and charges. We will do our utmost to ensure timely and accurate submission of your dental claims. However, we are not liable for terminated coverage, changes in eligibility, changes in coverage, denial of coverage, etc. This is your insurance; therefore, it is your responsibility to know your plan. Please notify us of any changes in insurers or coverage.

Payment plans
If required treatment puts a crimp on your budget, don't worry. We may be able to offer several payment options. We accept VISA and MasterCard. Additionally, we have available a healthcare credit card which may allow you to pay for your dental services, whether they are required or elective over a period of 3 to 6 months, or even longer if necessary. Please speak to our office manager / receptions about the option that might be right for you. We do not provide any type of in-house payment plan or office financing of any type.

Billing Charges
If we must bill you for outstanding charges, a five dollar ($5.00) billing fee will be added to the outstanding balance. Any account where the payable amount due is not paid by the second billing cycle, a finance charge of 1.5% per month (18% APR) will be added to the balance due.

Broken Appointments
A broken appointment charge will be assessed whenever a patient is a "no show" for an appointment or notifies the office less than one business day before the scheduled appointment of inability to attend the appointment.

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Acknowledgement and Acceptance:

I, _____acknowledge that Advances in Dental Care's financial policy has been explained to me and I agree that I am responsible for any and all charges for services rendered to me or my dependent, _____ irregardless of the fact that I may be covered by any insurance or third party plan. I agree to pay for any non-covered services, deductibles, co-insurance, elective services or other disallowed charges related to insurance plan exclusions and limitations. I also hereby give permission for treatment by Robert S Laurenzano, DMD, PC and any of its dentists that have been discussed and identified as necessary and appropriate.

Patient or Patient's parent or Guardian Date