Financial Policy

BABAK NOOHI, D.D.S., M.S. CAPITOL HILL DENTISTRY

Our goal is to provide you with the best possible dental care and to avoid any misunderstandings. We encourage our patients to discuss any questions they may have regarding our policies. If any problems arise, please discuss them with us promptly. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment:

1. We require that payment be made at the time of service. Payment can be made by cash, check, Visa, or MasterCard.
2. If the cost of treatment is $500 or less, the entire amount is due in full at the time the initial treatment is performed.
3. If the cost of treatment is more than $500, payment is as follows:
   a) At least **half** of the total cost is due at the time of initial treatment.
   b)The remaining balance can be made in equal monthly installments over the term of treatment. Otherwise, the remaining balance can be paid in two payments with the balance due at the time of final treatment. If the actual term of treatment is less than the projected term of treatment, the balance is due in full at final treatment.

Insurance. Patients who have dental insurance need to understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. *Your insurance is a contract between you and your insurance company. We are not a part of that contract.* Our office will file your insurance claims or can provide you a copy to file it yourself. We will also submit your pre-treatment estimates. In order for us to file a pre-treatment estimate with your insurance company we must be provided with a completed insurance form. Reduction or rejection of your claim by your insurance company will not relieve the financial obligation you have incurred in our office.

Photography. Please note that intra- and extra-oral pictures may be taken during your treatment. These pictures may be used for teaching and/or practice utilization and communication with the lab. without revealing your identity.

I, the undersigned, have read completely and agree to the terms of this financial policy and give my consent to use any photographs for teaching or training purposes.

_____ _____

Patient or Guardian Signature Date

Annual Update Only

_____ _____

Patient or Guardian Signature Date

Sincerely,

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