Barry LeJeune, D.D.S.

Financial Policy and Agreement

1130 Big Bethel Rd
Hampton VA 23666

For medical services rendered, including any and all services in the future, the undersigned responsible party for patient ______________________ (print), consents and agrees that full cooperation is expected in payment of the total charges of the undersigned due to owing to Barry LeJeune, D.D.S. The undersigned further acknowledges receipt and agreement to the financial policy outline below.

Dental Insurance Statement

Dental Insurance will gladly be filed as a courtesy for patients who carry insurance. However, insurance benefits due to this office after 60 days become the immediate responsibility of the person responsible for this account. Deductible, co-payments, and non-covered services are the responsibility of the patient and due at the time of service. Due to the large number of insurance plans we file, we cannot guarantee that any specific amount of any charge will be covered. Fees are estimated and our office cannot be held responsible for any amount not covered by insurance, including deductibles or annual maximum benefits. **Patients are expected to be familiar with their insurance coverage. Even though we try to accurately estimate coverage, there is no guarantee the insurance company will pay the estimated amount.**

Missed Appointments

From the very first appointment we establish open lines of communication so that we can work cooperatively toward the same goal... **your health.** If you are unable to make your scheduled appointment, **we request a minimum 48 hour cancellation notice.** Our hygiene education center was established to educate each patient to achieve the goal of eliminating future dental care. **Any cancellations made in less than 48 hours of the scheduled appointment will receive an assessed fee of $50.** If you need to cancel an appointment for any reason, call 48 hours in advance and talk directly to our office staff. Leaving a message or voicemail will be considered a cancelled appointment so please contact on of our staff directly and no fee will be charged.

Finance Charge

The person responsible for this account consents and agrees that full cooperation is expected in payment of the total charges of the undersigned due and owing to **Barry LeJeune D.D.S.** The undersigned agrees to be responsible for all charges not paid by a third party, including reasonable collection and/or legal fees if applicable. A service charge of $25 will be applied for any checks returned unpaid for any reason.

Patient Cooperation

Full patient cooperation is expected should additional services be rendered due to lack of maintaining prescribed preventative care, proper oral hygiene, or repeatedly missing appointments. The patient's account will be billed accordingly to these services.

The undersigned has read and understands the terms of this agreement.

Date: ________________________ **Responsible Party:**___________________________
(print)

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(signature)