Dental Serenity

17181 Wayside Dr., Dumfries, VA 22026 - (703) 445-9600
www.DentalSerenity.com

WRITTEN OFFICE POLICY

Thank you for choosing Dental Serenity where our mission is to deliver the best and most comprehensive dental care available. In order to provide the highest quality of care we require all patients must complete information forms prior to being seen by a doctor or Hygienist. A picture ID is also required.

For those with dental insurance, we are happy to bill your insurance company as a courtesy to you. We ask that you pay your estimated portion of the balance at the time of your visit. We will provide estimates as accurately as possible, however, please understand that we cannot guarantee these estimates. They are solely based on the information given to us by you and your insurance company. In order for us to bill your insurance properly, it is necessary for you to provide accurate and complete information at the time of your visit. **Please understand that the balance of your treatment is your responsibility regardless of your insurance compensation.**

For those without dental insurance, payment is expected at the time of service. Please note that alternative payment options are available through our "Serenity Club" yearly membership program and CareCredit financing. For more information about these programs please talk to our Front Desk Administrators for further details.

Dental Serenity requires a 50% non-refundable deposit towards your treatment. Appointments are scheduled on an individual basis, reflecting the amount of time needed to complete specified treatment; however, we do realize that everyone has busy schedules. If you need to cancel or reschedule an appointment, we ask that you please notify our office within 2 Business Days so that this time may be reserved for other patients in need. Failure to do so may result in a $50.00 late cancellation or broken appointment fee.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

If you have any questions please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Print Patient Name

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Patient Signature (parent if a minor) **Date**