ESTD. 1986

ANNAPOLIS
FAMILY DENTISTRY

Chris Anderson, DDS
David Johnson, DDS
914 Bay Ridge Road, Suite 110
Annapolis, MD 21403
410.267.7713

FINANCIAL AGREEMENT

Dr. Chris Anderson and Dr. David Johnson welcome you to Annapolis Family Dentistry. Thank you for choosing us as your dental care provider. We are committed to serving your dental health care needs as effectively, compassionately and efficiently as possible. The following outlines some of procedural details of the business operations of our office.

Full payment is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

If you have dental insurance, you are asked to please provide us with valid insurance information. We will submit claims for payment to your insurance company on your behalf. Any estimates from insurance companies do not guarantee the amount of payment until the claims have been received and fully processed by their offices. If you do not present us with valid dental insurance information, you will be personally responsible for the bill. Please be aware that some or perhaps all of the services provided may not be covered by your insurance policy.

Interest will accrue on unpaid balances after 30 days. There will be a minimum billing charge of $10.00 on unpaid balances, and monthly interest of 1.5% thereafter. If payment is delinquent, the patient will be responsible for any additional costs associated with collection agency services and legal fees.

For your convenience, we accept cash, check, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. There is a $25.00 service fee for returned checks.

Please note that 24 hours advance notice should be given for an appointment cancellation. A $50.00 missed office visit fee may be assessed.

I have read and accept the policies of Annapolis Family Dentistry stated above. I assume financial responsibility for and agree to make payment in full to Annapolis Family Dentistry for any charges for services provided to me not otherwise authorized by or paid for by my dental insurance. I authorize the release of any medical information necessary to process my insurance claims and authorize payment of dental benefits to Annapolis Family Dentistry.

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Signature Print Name Date