WASHINGTON FAMILY DENTISTRY, LLC
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TO ALL OUR PATIENTS

Due to rising costs in mailing statements and the increasing number of account defaults, we have made the following changes to our billing policy. Please review these changes listed below. These changes will take effect on September 1, 2011.

ESTIMATED PATIENT PORTION

1. Your estimated patient portion is due at the time of your visit. This has always been our policy but in the past, we have allowed a degree of leniency to it. Unfortunately, because of the economy and its consequent effects on everyone, there has been a steady rise in patients opting to be billed rather than paying for their portion during each visit. We will no longer be able to accommodate this leniency and will now strictly enforce our policy. Thus, beginning September 1, 2011, patients are required to pay for their estimated patient portion at the time of their visit. This includes insurance deductibles and any out-of-pocket or non-covered charges.

2. Your patient and insurance portions are estimates based on information we have received from you and your insurance company. Should there be a difference in what we estimated and the final calculations obtained from your insurance company, we will make the necessary adjustments (referred in the statements you may receive as "PPO Write Off," "ParAdjOverEst" and ParAdjUnderEst").

3. ParAdjOverEst means that our submitted charges to the insurance have been adjusted by the insurance company to reflect their fees which may be higher than what we have originally submitted. This may result in an additional balance to your account. ParAdjUnderEst means that our submitted charges to the insurance have been adjusted by the insurance company to reflect their fees which may be lower than what we have originally submitted. . This may result in a credit added on to your account. "PPO Write Off" means that we are a preferred provider for your insurance company and that the service we have rendered may not have a fee associated to it because of contractual agreement between us and your insurance company. The "Explanation of Benefit" from your insurance company is what we use to determine if any of these adjustments or fee changes should be made.

4. Consequently, a statement will be mailed to you detailing the activities and the balance or credit on your account. As stated previously, such statement is only as a result of insurance transactions that occur after your visit and after your payment of your estimated patient portion. In other words, we will no longer "wait to see what the insurance will pay" before asking for your estimated patient portion.

MONTHLY STATEMENTS

1. Effective September 1, 2011, all estimated patient portion will be due at the time of visit. Statements, when they are generated, are for balances carried over due to adjustments made to the account based on the "Explanation of Benefit" statements from your insurance company and from any carried over balances.
2. All statements sent out are due upon receipt. You agree to pay the full amount shown on the PATIENT PORTION in full within 25 days.
3. If we do not receive full payment of any statement by 25 days from the statement date, you will be charged a late fee of $15.00 for each month that your account balance is not paid. The late fee will appear on your next statement.
4. In addition to the late fee, the unpaid balance will incur a finance charge. The finance charge will be based on a periodic rate of 1.5% per month (annual percentage rate of 18%).
5. Returned checks will incur a $25.00 service fee.
6. Accounts with 90 days of aged balances will be turned over to our collection agency. You will receive a written notification from us prior to such action on our part. If you are unable to pay the remaining balance, you may make arrangements with the office to charge your credit card (Visa, MasterCard, American Express, Discover, CareCredit) monthly. The amount charged monthly on your credit card shall be no less than 10% of the aged balance.
7. Late payments or defaults on your account may be reported to credit bureaus and may affect your credit rating. If you think we have reported inaccurate information to a credit bureau, you may write to us at the address shown above.

IN CASE OF ERRORS OR QUESTIONS ABOUT YOUR CHARGES OR STATEMENT

If you think that a statement or charge is erroneous, you must contact us within 60 days after the error appeared on your statement. You must notify us of any errors in writing. While we entertain phone calls in regards to billing issues, written notification is our preferred method.
While we investigate whether or not there has been an error:

1. We cannot try to collect the amount in dispute nor can we report you delinquent for that specific amount.
2. The amount disputed will remain on your statement and will continue to accrue late and interest charges. If we determine that we have made a mistake, we will deduct the disputed amount, as well as any interest or late fees.
3. Although you do not have to pay the amount in question, you are still responsible for the remainder of your balance. The remaining balance must be paid in full or interest and late fees will be incurred.
4. At the completion of our investigation, we will notify you in writing of our decision. At that point, if we think you owe the disputed amount and you choose to not pay, we may turn over your account to our collection agency and may report you as delinquent to the credit bureaus. If you object in writing to the conclusion of our investigation and you refuse to pay the amount in dispute, we may proceed in sending your account collection and reporting you as delinquent however we must inform anyone we report you to that there is still a question about the balance. We must also inform the credit bureaus or collection agency when the matter has been settled in its finality. If we fail to follow these rules, we cannot collect the first $50 of the amount in dispute, even if the disputed amount was correct.
5. Any collection agency fees, will be added to the account balance and will be the patient's responsibility.

Patient/Guardian Signature: _____ Date: _____