CENTRAL VIRGINIA FAMILY DENTISTRY

20936 TIMBERLAKE ROAD
LYNCHBURG, VA 24502
434-237-0004

192 SOUTH MAIN STREET
AMHERST, VA 24521
434-946-2480

Welcome to the office of Dr. Davis and Dr. Howard. We are happy to provide you with quality family dental care. In order to provide you with the best service possible we request that you understand our financial policy as listed below.

Payment is required at time of service. You may accomplish this in the following ways:

1. All major credit cards are accepted here.
2. Cash and personal checks are welcome. A $25.00 charge will be charged for all returned checks.
3. As a courtesy to our insurance patients we will file the insurance claims for you. However, any quoted benefits or prices are ONLY an estimation, and the patient is ultimately responsible for understanding their insurance coverage and paying any balances on their account. We also ask you to pay your required deductible and your estimated portion at the time of service.
4. A payment plan is made possible by Care Credit. There are 6, 12, and 18 month no interest plans, plus extended plans with reasonable interest rates. Applications and more information are available at the reception window.

IF ANY BALANCE IS OVER 90 DAYS IT IS SENT TO AMERICAN CREDIT BUREAU, INC. AND THE ACCOUNT IS CLOSED.

If you have to cancel your scheduled appointment, please give us 24 hours notice. Charges may be made for broken appointments without notice. **Broken appointments may result in a $50.00 charge before we can treat you again.**

Thank you for choosing our office to provide you with friendly, gentle, quality dental care. If you have any questions please ask one of our staff.

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Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Patient Name: _____

Patient Date of Birth: ____/____/_____

Signature: _____

Over Please ☛

Today's Date: _____/_____/_____

Account Information

Person ultimately responsible for account

Name:_____ Relation:_____

Billing Address:_____
City State Zip

Social Security #_____ Driver's License#_____

Date of Birth _____/_____/_____ Phone#_____

Payment Method

☐Cash ☐Check ☐Credit Card_____
Number Expires Code

_____ (**initial**) I hereby authorize assignment of my insurance right and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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❖We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

❖Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

❖I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❖I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ (**initial**) I acknowledge that I have received a copy of the Summary of Privacy Notice

Signature_____ Date_____/_____/_____
☐Adult Patient ☐Parent/Guardian ☐Spouse