dentaldesigns
OF WHITE MARSH

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Financial Policy

This is an agreement between Dental Designs of White Marsh (Liangkai Weng DDS LLC) as creditor, and the Patient/Debtor named on this form.

In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Dental Designs of White Marsh (Liangkai Weng DDS LLC).

By executing this agreement, you are agreeing to pay for all services received.

- **Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

- **Payment options:**
    a. For all dental work administered, unless alternate arrangements have been discussed and approved by us in writing, 100% of the office fee is required at the time service is rendered. Any remaining balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.
    b. For those with or without dental insurance, we offer CareCredit for those looking for financing their co-pay. Please ask our financial coordinator for more information.
    c. For those without dental insurance, enroll in our Dental Wellness Program which covers 100% of routine preventive dental visits, along with significant discounts on most non-cosmetic procedures. Find out more information on our website at DentalDesignsofWhiteMarsh.com in the New Patient section.

- **Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. **We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may**

pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. In the event of an overpayment by your insurance company, we will issue a refund.

- **Required Payments:** There is a fee of $50 for any checks returned by the bank.

- **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees incurred plus all court costs.

- **Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact you received treatment at our office may become a matter of public record.

- **Divorce:** In case of divorce or separation, both parties will remain responsible for the account. After a divorce or separation, the parent authorization treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorization parent's responsibility to collect from the other parent.

- **Effective Date:** Once you have signed this agreement, you agree to ALL of the terms and conditions contained herin and the agreement will be in full force and effect.

FOR YOUR CONVENIENCE WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, AND DISCOVER.

Patient's Name: _____

Responsible Party (If not the patient): _____

Patient Signature: _____ Date: _____

Co-Signature: _____ Date: _____