400 S. Maple Ave, Suite 103, Falls Church VA 22046 | 703.752.4253

FINANCIAL AGREEMENT

We believe it is important not only to provide the highest quality dental care, but also to make this care affordable for our patients. Please ask us any questions you may have. We are glad to assist you. We have made arrangements for our patients, which allow payment made to be convenient and flexible. We are committed to helping you to receive the dental care you desire and the most pleasant dental experience as possible.

Notice to Patients with Insurance. Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. Payment to our office remains your responsibility, regardless of how much your insurance does or does not pay. For extensive treatments, most insurance companies require pre-treatment estimates. We'll be happy to supply any information to your dental insurance carrier needs and help you to receive the maximum benefits.

Permission is given to the physicians/dentists and staff of Gentle Touch Dental, P.C. to treat the patient named below. The undersigned person below is responsible for the patient's account and must be the legal and/or financial guardian or parent to the patient who is a minor (under 18 years old) and agrees to all the terms and conditions stated on this document.

Note: To avoid the dangers of drug abuse or other harmful implications to our patients, pain medication is prescribed ONLY in conjunction with required treatment and NOT prescribed instead of treatment. Antibiotics may be prescribed prior to performing a procedure, as determined by a doctor.

Methods of payment: Master card, Visa, American Express, Discover, Cash, Check, Care Credit

I fully understand the above and agree to conform accordingly.

AUTHORIZED SIGNATURE: ______________________ PRINTED NAME: ___________________________
Date: ____

*Thank you for reading our Office Policy. Please let us know if you have any questions or concerns. We appreciate the trust and confidence you have placed in us for your **dental care.***