PRP Dental
1522 Pointer Ridge Place Suite E
Bowie, Md 20716
301-249-1102

Financial Policy

Thank you for choosing PRP dental for your oral healthcare. Our team is committed to your overall Health and the success of your treatment.

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available In the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health.

Using dental insurance:
All charges you occur are your responsibility regardless of your insurance coverage. Co-pays, deductible and non-covered procedures must be paid at the time services are rendered.

We will gladly process your insurance claims provided that you give us your insurance information. However, please be aware that certain procedures and services may not be covered as dental insurance is designed to **reduce** your cost but **not to eliminate it**. Also, please understand that your insurance is a contract between you and your insurance company; therefore, it is your responsibility to learn about your policy's coverage, exclusions and limitations. It is also your responsibility to make sure that we are in network with your plan.

Cancellation Policy:
Appointment times are exclusively reserved for each patient. Please respect this by giving us 24-hour advanced notice for any appointments you need to change or cancel. **Failure to notify us within 24 hours will result in a missed appointment charge of $150.00 for appointments scheduled with the doctors and $75.00 for hygiene appointments. Also, if you arrive more than 15 minutes late your appointment will need to be rescheduled as it is unfair to keep the next patient waiting to be seen.**

As a courtesy service we will do our best to make reminder/confirmation calls prior to your appointments, ultimately it is your responsibility to remember your appointment and make changes as necessary.

Returned checks:
There will be a of $50.00 fee for returned checks and a of $100.00 fee for cancelled checks.

Consent for Service;
I consent to the services, treatment and/or procedures recommended by the dentist and diagnostic methods deemed appropriate by the dentist which may include x-rays, study models, imagery, and other aids. I acknowledge and understand that the dentist may employ the assistance of others in performing such service, treatment and/or procedures and diagnostic measures.

Payment for services: We accept Visa, master card, American express, discover, cash, checks
Outside financing through Care credit and Lending Club

I have read and understand this financial agreement and I agree to the terms and accept responsibilities as described above.

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Signature printed name Date