Fernando J. Juliao, D.D.S., P.A.

8109 Harford Road, Suite D, Parkville, MD 21234
Phone: 410-665-0877

Our financial policy

Thank you for selecting us as your family's dentist. We are committed to your treatment being a positive experience. Therefore; we would like to clarify our financial policy in advance of any treatment:

1. Full payment is due at the time service is rendered. For your convenience payment options include:
   Cash, Check, Money Order or Credit Card.
   (Discovery, MasterCard, Visa or American Express)
2. We attempt to estimate your and your insurance payment obligations. Actual charges may differ.
3. Minor: Must be accompanied by a parent or guardian for all appointments unless a written consent form is obtained. The adult accompanying the minor is responsible for full payment.
4. Broken or failed appointments: Your scheduled appointment has been reserved at your request. Unless cancellations are received at least 24 hour in advance, a fee of $35.oo dollars may be charge to your account for a regular appointment or $ 65.oo for every half an hour for an appointment longer than an hour. This time is required, in order to offer time to another patient in need. Please help us avoid charging a fee by keeping your scheduled appointments.
5. A $35.oo dollars fee is charged for all returned checks.
6. Collection, billing or/ and late fee will be added to your account for anything past due balance.

The following applies to those patients with dental insurance:

7. If, at your first appointment, we are unable to verify your dental insurance or cannot obtain a list of benefits, **full payment is due at the time services are rendered.**
8. Patients are responsible to pay their deductible and estimated co-payment at the time services are rendered. A refund check will be mailed if the insurance carrier pays more than was estimated.
9. **We will attempt to give you an estimate**. Remember this is only an estimate, some things may change.
10. While filing insurance claims is a courtesy we extend to our patients, we must emphasize that as dental providers, our relationship is with our patients – not the insurance company. In the state of Maryland, insurance companies are requested to send payment within 30 days. If full payment is not received from your insurance carrier within 45 days, the balance becomes your responsibility and is subject to a billing fee and 18%APR finance charge.

I have read the above policies agree to abide by them.

Patient's name: _____

Signed_____ Date_____
(By Patient, Parent or Legal Guardian)

CR 10-28-05