**Dr. Talib Ali DMD**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Pharmacy Name & Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policy**

Thank you for choosing **Purcellville Dental Care** as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, MasterCard, Visa, Discover, American Express, and Care Credit. Outstanding financing (payment plans) is available upon request and approval.

**Please Note:** Returned checks will be subject to additional fees. In the care, it becomes necessary for our service to enlist a collection of service and/ or legal assistance, you will be responsible for any collection and/or legal charges up to 35%

* We strive to render excellent dental care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when its missed, that time cannot be used to treat another patient. We ask that you give our office 48 hours’ notice (if calling on a day that the office is closed, a voicemail with your name and appointment date and time is required to properly cancel) if you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time or do not show up for your appointment, this is considered a missed appointment. A fee of $100.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled no can records be transferred without the payment of this fee. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $100.00 cancellation fee will be charged. After missing three appointments with or without notice, you may be placed on a same day scheduling policy for treatments, which would not allow you to schedule any appointments in advance. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.
* We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, MasterCard, Visa, Discover, American Express, or Care Credit at the time we provide the service to you.
* Insurance Payments are ordinarily received within 30-60 days of the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
* We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter a dispute with your insurance company over any claim.
* Thank you for choosing **Purcellville Dental Care** as your dental care provider. We are committed to providing you with the affordable and highest quality lifetime dental care.
* As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not guaranteed that your insurance will pay exactly as estimated. Any part of your bill not covered by your insurance or denied payment will be your responsibility.

**CONSENT:** I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made

**CONSENT:** I authorize **Purcellville Dental Care** and its’ staff to take X-Rays and Photos to aid in diagnosis, treatment, and patient education.

By signing below, you are authorizing us to call you and/or email you at any number/email you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an upcoming call from us, and/or outgoing calls to us, to or from and such number, without reimbursement from us.

**Patient and/or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**