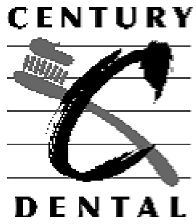

P. Golestani, DDS
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Suite 100
Germantown, MD 20874

TEL: (301) 972-1600
FAX: (301) 972-3644
p.golestanidds@verizon.net

OFFICE POLICIES

This form is provided to help eliminate any misunderstandings that can arise. Please initial each paragraph and then sign and date at the bottom.

_____Our fees are meant to be fair and reasonable. Our office is happy to inform you of your anticipated fees prior to treatment upon request. To keep overhead down we expect payment the day of treatment. However, larger cases can be divided into 2 payments if arrangements are made prior to the start of services. We also participate with Care Credit if you would like to spread your payments over a longer period of time. To make payment convenient for you, we accept cash, personal checks, all major credit cards and we participate with Care Credit.

_____If your account is not paid in full or a payment schedule arranged within 3 billing cycles (approx. 90 days), **a collection fee will be charged.** Collection fees are as follows: 25% over $500, 35% for $100 to $500, and 50% for balances up to $100.

_____Any returned checks are subject to an additional fee of $25.00 or higher depending on what our bank charges us. Immediate remittance in the form of cash, credit card or certified check is expected.

_____There is a $50.00 per ½ hour charge for all cancellations/no shows. We require **2 business days** notice. We understand that emergencies can occur, therefore if it is your **1st** missed appointment; you may request a waiver of this fee. The exceptions to this are appointments scheduled before 9am, after 4pm and group appointments. There will be absolutely **NO** waiver for the fees for these appointments.

I HAVE READ THE ABOVE INFORMATION AND ACCEPT RESPONSIBILITY FOR ANY FEES I INCUR DUE TO TREATMENT, COLLECTIONS, RETURNED CHECKES AND MISSED APPOINTMENTS.

PRINT NAME____

SIGNATURE OF PATIENT____**DATE**__________________
OR PARENT (If minor)