Burns Family Dentistry, P.C.
Dr. G. Preston Burns III, D.D.S.
242 Butler Road, Suite 101, Fredericksburg, VA 22405
Phone: *(540) 373-6557* ***Fax:*** *(540) 373-6562*

Office Policy Concerning Insurance

Please be advised that our office is not responsible for what your insurance pays or does not pay. We do our best to give you an accurate estimate of your work and what your insurance pays, and what your portion will be. You are responsible for any balance that remains after the insurance company does not pay. It will be your responsibility to follow up with the insurance company on any unpaid claim, and pay the outstanding balance due to our office, in the event that a claim has not been paid after sixty (60) days. Should the account be turned over to collections, the undersigned agrees to pay one third attorneys fees and all costs associated with the collection procedure.

Please Note: the only insurance we participate with is as follows: Delta Dental and Anthem BCBS. All other policies are considered out of network. We will happily bill another insurance for you, but please note we are not participating so you may have a higher out of pocket expense.

We do not bill to secondary insurance companies. We will be happy to supply you with the information so you can file on your own. Exception, if we are participating with your primary insurance and you have a secondary insurance that we also participate with, we will then bill for you.

Your co-payment and payment for any work not covered by insurance must be paid the day you have your work done. We accept checks, cash, money orders, Master Cards, Visa, Discover, American Express and Care Credit for your convenience.

Your appointment time is reserved exclusively for you. If you are unable to make your appointment, a 48-hour notice is required to avoid a $75.00 missed appointment fee.

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to my dentist Dr. G. Preston Burns (Burns Family Dentistry). (This authorization applies only to non-participating dentist. Claim payments are mailed directly to participating dentists.)

*** Please acknowledge your understanding and acceptance of this policy with your signature and today's date.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

Response Date: _____