

Merrifield Dental

Dr. Jerry Kim and Dr. Edison Abril

8622 Lee Highway, Ste. A, Fairfax, VA 22031 703-876-4600

We are very pleased that you have chosen our office for your dental care. The staff is proud to have the opportunity to provide you with gentle, efficient, and state of the art dental services. We hope to make your visits with us as pleasant and comfortable as possible. Please take a moment to familiarize yourself with our office policies and procedures, and let us know if you have any questions or concerns.

Office Policy

1. Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when we collect your portion for our services at the time of service.
2. Our staff will tell you the approximate estimated fee for treatment prior to the next appointment. To make payments convenient for you, we accept cash, personal, business checks, Visa, or MasterCard.
3. If you have any questions regarding your insurance coverage or co-insurance payment please let us answer your questions before treatment begins. Otherwise, we will assume that you are familiar with your dental plan coverage and limitations.
4. Payment and or co-payment as well as deductibles are required in full at time of service. Any difference will be credited or billed after the insurance payment has been received.
5. Please be advised that any co-insurance payment amount is just estimated based on the information given by the insurance company at the time the plan was verified. The information given over the phone is not a guarantee of payment by the insurance company, and actual payment may differ. Any insurance payment not received after 60 days, you, the patient will be ultimately responsible for the full amount.
6. If an outstanding account has not been paid within 120 days, a monthly service charge will be added. If the account is not cleared, our office will turn over the account to our attorney for collection.
7. If you have any questions about your dental coverage, your account, and/or this policy, please does not hesitate to ask us.

I have read and understand the above policy, and agree to be held financially responsible.

Patient's Signature or Guardian

Date