Barry S. Edland, DDS, PA
801 Toll House Avenue, Suite C-2, Frederick, MD 21701
301-662-5441

Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately after treatment is rendered.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement.

A returned check fee of $35.00 will be applied and must be payable from you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.

If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total. Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider may be sent to determine an approximate final investment. However, it is an estimate only. Final insurance payments may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment. We will wait up to 60 days to hear from your insurance company, and then it will be your responsibility to pay your account in full.

I understand that a $50.00 fee plus attorney and court costs will be added to my account for any unpaid balance that are sent to the attorney or collections agency to assist in collection of the unpaid balance.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that
I am ultimately responsible for all fees for services rendered to me and/or my family.

Patient Name_____

Patient/Parent/Guardian Signature_____

Date_____