Dr. Angela D Petros, PLLC

902 First Street

Moundsville, WV 26041

304-845-9665

Office Policy

THE PATIENT IS RESPONSIBLE FOR FEES, REGARDLESS OF INSURANCE COVERAGE Our insurance department exists as a courtesy and convenience for you. The relationship is between you, the insured patient, and your insurance company. Any questions about insurance should be discussed with them. Our office will make every effort to determine the extent of your insurance coverage and to provide appropriate information so as to maximize your benefits. The insurance company may give us an indication of that coverage.

Payment for services will be due on the day of the procedure. These monies will be applied to the patient co-payment required by your insurance company. This payment is only an estimate of benefits and may need to be adjusted once final payment is determined by your insurance company. If there is a balance owed on the account, you will be billed at that time.

The insurance companies are required to respond to a claim within thirty days. When there is overlapping coverage, response time may be increased. Timing of the insurance payment is out of our control. Our office makes every attempt to control increases in medical costs. To that end, our accountants state that we must have payment for services rendered within eight weeks. Therefore, if your insurance company has not made payment for your care within eight weeks, we must bill you for the service. To avoid this, we would advise that you contact your insurance carrier if you have not been notified of payment by six weeks after your visit.

Our office reserves a time for you if you must cancel your appointment, we require (24) twenty-four hours notice so that we may have an opportunity to give that time to another patient. Any appointment cancelled without at least twenty-four (24) hours notice prior to your scheduled time will be subject to a $50.00 fee. This fee is not covered by any insurance company and would be an out of pocket expense to you.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. Necessary forms will be completed to expedite insurance carrier payments after payment is received from the patient. Co-payment is requested at the time of the visit.

It is customary to pay for services when rendered unless other arrangements have been made in advance.

AUTHORIZATION TO PAY BENEFITS TO THE DENTIST. I hereby certify the above named services were rendered and direct payment may be made to the Dentist named hereon. I am financially responsible for charges not covered by my insurance. I request that payment of authorized benefits be made to Dr. Angela D. Petros, PLLC for any services furnished to me by the Dentist.

After you have read the information listed above please sign below:

X_____ DATE:_____