NOVA Orofacial Pain, TMD & Dental Sleep Medicine
5222 Rolling Rd.
Burke, Virginia 22015
703-389-0111 Fax: 703-389-7755

PATIENT FINANCIAL RESPONSIBILITY FOR SERVICES

The providers and staff of NOVA Orofacial Pain, TMD & Dental Sleep Medicine are committed to providing you with the best possible care and to help you receive your maximum allowable insurance benefits. While the filing of insurance claims for contracted insurance carriers is our obligation, all fees are ultimately your responsibility. We recommend that you be completely familiar with your individual coverage, benefits, limitations, and exclusions. All questions in this regard should be addressed to your insurance carrier directly. Please be aware of the following important financial responsibilities:

PLEASE CHECK: It is **your** responsibility to keep all insurance and demographic information up to date.

_____You must **make all co-payments at the time of your visit, as well as payments for any deductibles, co-insurance, or non-covered services**.

_____If a referral is required for your visit while you are seeing the Orofacial Pain Specialist, **it is your sole responsibility to arrive for your appointment with your required referral**. If you do not have the required referral at the time of your appointment, you will be required to pay the full 50% of the appointment fee at the time of service.

_____**If you cancel or reschedule a New Patient appointment with less than a 48-hour notice, you will forfeit the deposit of $150.**

_____**For our contracted insurance carriers' patients that cancel or reschedule their New Patient appointment with less than 48-hour notice, there will be a late cancellation fee of $150**.

_____**If there is a No-Show or Cancellation on the day of your New Patient appointment, we will charge the full appointment cost of $509.25 (No exceptions).**

_____**If you do not show up to your Follow-Up appointment, we will charge a No-Show fee of $50 (No exceptions).**

_____You may pay in the form of cash, check, HSA/FSA, CareCredit, and/or credit card. **We will assess a fee of $30.00 for returned checks**.

_____ If your account becomes delinquent, **your account will be transferred to our collection agency and attorneys, at which time you will be responsible for all collection costs including attorney fees, court costs, and all civil penalties as provided by the Code of Virginia**.

I authorize NOVA Orofacial Pain, TMD & Dental Sleep Medicine to submit my insurance claim on my behalf and I am financially responsible for all services rendered to me. I hereby consent to the release and re-disclosure of my medical records to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer, or other health benefit plan. This consent applies to NOVA Orofacial Pain, TMD & Dental Sleep Medicine, or Carol Gabriel, PC.

I have read the above Patient Responsibility Info for Services and have provided true and correct insurance and demographic information. I will promptly notify you of any changes to my health insurance carrier, including new ID Numbers with my current carrier.

_____	_____	_____
Print Name	**Patient/Guardian Signature**	**Date**