Muss Family Dentistry
Nicholas A. Muss D.D.S.
Arwa Y. Zeineh D.D.S.
Sun Ryu D.D.S.

FINANCIAL AGREEMENT

Patient Name _____

Patient Address: _____

_____

Dental Insurance Company: _____

Patient Social Security Number: _____

I, the undersigned, hereby agree to pay the above named doctor all fees due to him for services rendered and/or expenses incurred by me, my spouse or any of my children or dependents. Payment is to be made at the time of service or incurring of expenses.

I understand that the payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by my insurance company are my responsibility. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow through, or confirmations.

If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty-three and one-third percent of the unpaid principal and interest that is or becomes due, plus all court costs and interest in the amount one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. I understand and agree that the terms herein are reaffirmed each time services are received. I further agree to pay returned check charges of $25.00 per returned check.

Undersigned further agrees to pay a charge of $50.00 per half-hour of reserved appointment time when cancellation notice of at least 24 hours is not given.

Patient Signature: _____

Date: _____

131 Elden Street, Suite 2C2 Herndon, VA 20170
(703) 689-2697
info@mussfamilydentistry.com *www.mussfamilydentistry.com*

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Nicholas A. Muss D.D.S.
Arwa Y. Zeineh D.D.S.
Sun Ryu D.D.S.

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options, please initial one:

____ Payment by cash

____ Payment by personal check

____ Payment by debit or credit card

____ Automatic monthly billing to your Visa, MasterCard or Discover card.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Health Savings Account (HSA) Visa and MasterCard to cover amounts not paid by your insurance.

If you opt to self-pay, you may also choose a comfortable amount to be automatically billed to your personal Visa, MasterCard or Discover on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Patient Name: _____

Patient Signature: _____

Date: _____

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