

**Brent A. Rusnak, D.D.S., PC**  
**M. Walter Young, D.D.S.**

***Office, Dental Insurance Information and Financial Policies***

**Dear Patient:**

**Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family will feel welcome to our dental family.**

**Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. Please choose the option the works best for you.**

**◆Dental Insurance-If you have dental insurance, as a service to you, we will complete your insurance form with all the necessary information and submit it to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered.**

**◆If your insurance company has not made a payment within 45 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship).**

**◆Monthly payments- If you need to make long-term payments we can offer financing with Unicorn Financial. You must qualify to use this option.**

**All patients with an outstanding balance will receive a statement each month. We reserve the right to apply a billing charge of 1.5 % (18% APR) on all accounts 60 days overdue.**

**We reserve the right to charge for appointments broken with out proper 24 hours notice.**

**SIGNIFICANT EXPOSURE- Section 32.1-45,1(A) and (B), Code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and /or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.**

**I authorize and release information and payment of my dental insurance to the dentist.**

**I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges incurred to collect this account) on the principal balance of 18% (eighteen) per annum from the date of service.**

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Signature of patient or guardian

\_\_\_\_\_  
Date