Daniel E. Cassidy, Jr. D.D.S.
2835 Duke St.
Alexandria, VA 22314

Patient Financial Agreement and Responsibility Form

1. Financial Responsibility for All Patients

I understand that all dental services furnished are charged directly to me and that I am personally responsible for payment of all dental services.
Dr. Daniel E. Cassidy's office may impose reasonable interest, late charges, direct collection agency costs and or reasonable attorney's fee should my account become delinquent. Any account balance over 60 days will be assessed a fee of 18% (per annum) of the balance due. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency.

2. Patients Who Carry Dental Insurance

I certify that the information I have provided regarding my insurance coverage is correct and authorize Dr. Daniel E. Cassidy's office to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I understand if my insurance company refuses to pay or pays less than estimated, that the dental insurance is designed to offset the costs of my dental treatment and should not be an obstacle to obtain the recommended health services. I agree to pay any payments, co-payments, or deductibles as required by my insurance plan for dental care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

Non-Covered Services

I agree to pay for dental services provided to me or my dependent which are not covered by the benefits in my insurance plan.

3. Appointment Cancellation Policy

Dr. Daniel E. Cassidy's office may impose a no-show fee of $65.00 for appointments cancelled less than 24 hours notice.

I Agree to the Above Stated Responsibility and Policy

_____
Patient Name Printed

_____ _____
Signature of Patient or Legal Guardian Date