13841 Hull Street Road, Suite 4
Midlothian, VA 23112
804.739.0963 | 804.745.0100

Pediatric Dentistry and
Orthodontics of Virginia
www.pdova.com

651 Southpark Boulevard
Colonial Heights, VA 23834
804.526.9815

Orthodontic Financial Responsibility

April L. Bridges-Poquis, D.D.S.
Chad Schanilec, D.D.S.

Financial Responsibility Statement

In consideration of services to be rendered to my child at my request, ***I understand that I know and agree to pay Pediatric Dentistry and Orthodontics of Virginia. I also understand that if any check or charge rendered by me for payment of services is return for any reason; a fee will be billed to my account and $50. Also, if there is any outstanding balance on my account for over 60 days, I finance charge of 1.5% will be applied monthly.*** I agreed to be responsible for any fees incurred if this account becomes delinquent and requires collection through the American Credit Bureau or an Attorney. ***I understand that these fees may add up to 33%*** of the total due on my account at time of collection and including previous interest accrued prior to turning this over to collections.

Monthly Payments

I understand that I will be billed monthly for orthodontic services as stated in my orthodontic contract. I understand that a monthly payment is due on my orthodontic account regardless of appointment schedule. Payments are due by the 25th of each month.

Extractions or Surgical Procedures

Dr. Bridges-Poquis/Dr. Schanilec may indicate that extractions or surgical procedures are required before or during the orthodontic process. Please be advised that payment for these services, performed by your dentist, may be deducted from your orthodontic maximum, reducing the benefit paid to Dr. Bridges-Poquis/Dr. Schanilec.

Insurance Information

I understand that Insurance claims will be submitted to my carrier as a benefit to me. It is my responsibility to provide a copy of my Dental Insurance Card and Completed Dental claim form on or before orthodontic appliances are placed. If for any reason the claim is denied, rejected, incorrectly filed, or needs to be filed with a different carrier, it is my responsibility to supply the business office with the correct information to get the claim paid. If insurance benefits are not paid for any reason, I understand I am responsible for the total contract balance.

Flex Account or Cafeteria Plan Information

I understand that the business office will furnish a statement of payment once orthodontic charges and payments are posted on my account so I can be reimbursed by my employee flex account. I understand that no employee of Dr. Bridges-Poquis/Dr. Schanilec will provide receipts of payments not actually received or falsify charges not actually incurred. I understand the business office may state the dollar amount I will be billed in my flex year.

Termination of Treatment

I understand Dr. Bridges-Poquis/Dr. Schanilec will use her/his best efforts and judgment in exercising her/his skill, knowledge, and experience to provide me with a quality orthodontic result and experience. I will cooperate with regard to keeping scheduled appointments, following all instructions, and promptly paying for services rendered. I understand that Dr. Bridges-Poquis/Dr. Schanilec may terminate the doctor patient relationship even though treatment may not be completed, if problems of this nature persist without adequate resolution on my part.

Signature: _____ Date: _____

Printed Name: _____ Patient Name: _____

Meera Gokli, DDS
Pediatric Dentist
Diplomate American
Academy of Pediatric Dentistry

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Pediatric Dentist

David Keeton, DMD
Pediatric Dentist
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April Bridges-Poquis, DDS
Orthodontist

Chad Schanilec, DDS
Orthodontist