WELCOME

Dr. Michael R. Pollowitz & Dr. Sharon F. Brown.

are committed to providing you with superior

Cosmetic, General & Preventive Dental Care

WASHINGTON CENTER
for Cosmetic Dentistry

INSURANCE / FINANCIAL POLICY

Our office is an Out of Network provider to all dental insurance companies. As a courtesy we will gladly submit your claim to your dental insurance company, we will need you to provide us with the proper information in order for us to do this. You will be expected to pay your estimated portion when services are rendered. If you are unable to provide us with the proper information to submit your claim, you will be financially responsible for your dental work at the time of your visit.

Please remember you are fully responsible for all fees charged by our office regardless of any insurance benefits including any balance remaining after insurance benefits and or co-pays. Our office will bill you directly for any claims left unpaid by your dental insurance after 60 days.

Name (Print) I _____ have read and acknowledged this policy

By signing below, I agree to these terms

Signature: _____ Date: _____

For your convenience we accept Cash, Checks, & all Major Credit Cards.
If you have any questions or concerns, please give our office a call at 202-363-2500. Many times a simple phone call can clear any misunderstanding you may have.

OFFICE CANCELLATION POLICY

. Please Help us Help you

Your appointed time has been reserved exclusively for you and a no show or short notice cancellation affects you, us, and other patients that would have wanted that appointment.

Our office has a 36 hour (business day) cancellation policy. A fee is charged for all short notice cancellations (or) no shows. Hygiene appointment fee is $50.00 and a Doctor appointment is $150.00 for each scheduled hour that was reserved. Though your appointment date & time is your responsibility as a courtesy we do our best to try and remind you, with emails, texts, and phone calls. If an appointment needs to be rescheduled please be kind enough to give us proper advance notice.

Name: (Print) I _____ have read and acknowledged this policy.

By signing below, I agree to these terms.

Signature: _____ Date: _____

Revised May 2013