D.C. Dental Care, P.L.L.C.
405 Chatham Square Office Park
Fredericksburg, VA 22405

Phone (540) 373 4444
Fax (202) 609 9672

Dr. Dana Culda, DMD

Payment/Cancellation Policy

Payment at the time of services is expected. For your convenience, we take Cash, Check, Credit or Debit cards.
Our office will be happy to submit claims to your insurance company as a courtesy. A service charge of 18% per month will be added to all balances 60 days and older. I understand that DC Dental Care will make every effort to collect from my insurance company. Provided the patient promptly furnishes the provider with the correct insurance information. I hereby authorize DC Dental Care to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account is turned over to a collection agency, I hereby agree to pay thirty five percent (35%) collection agency fees on the unpaid balance.

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointment times at DC Dental Care are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In order to continue to provide you with affordable fine dentistry for you/your entire family, we maintain a No-Show/Cancellation Policy for all of our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least 48 hours in advance of the appointment. Cancellations must be made during normal business hours on workdays. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made 48 business hours before their appointment.
Every appointment missed or cancelled with less than 48 hours' notice, or no show, a $75 charge will be billed.
This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

Signature: ________________________________ Date: ___________________

Print Name: _______________________________