ENDODONTIC EXCELLENCE
WHERE CARING IS OUR SPECIALTY

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ENDODONTIC EXCELLENCE FINANCIAL POLICY

Payment Expectations

At Endodontic Excellence of Reston, we are committed to providing you with high-quality endodontic care. To ensure a seamless and timely payment process, we require all patients to complete a credit card authorization form.

Payments are expected at the time of service, including:

- Co-payments
- Co-insurance
- Unmet deductibles
- Any non-covered charges from your insurance provider

For patients without insurance coverage or those with pre-existing condition exclusions, full payment is required at the time of service.

Insurance Coverage & Patient Responsibility

While we make every effort to obtain accurate insurance benefit information, it is ultimately your responsibility to understand your insurance coverage. Please be aware that:

- Insurance estimates are subject to change based on claim processing.
- Any discrepancies between estimated and actual coverage will result in a patient responsibility balance**.**
- If an overpayment occurs, we will process any applicable refunds within **30 days** of discovering the discrepancy.

Credit Card Authorization & Secure Storage

By signing this form, you authorize Endodontic Excellence of Reston to securely store your credit card information for the sole purpose of charging or refunding any remaining balances after insurance claim processing.

We will make every effort to notify you of any charges or refunds through **phone calls, emails, and mail** over a 30-day period. If we do not receive a response, we will proceed with processing payments or refunds using your saved credit card information.

Outstanding Balances & Collections

- If your saved credit card information is invalid and payments remain outstanding, we may refer your account to a **collection agency**, which could impact your credit score.
- If a refund is due but your credit card information is invalid, we will issue a check to the **mailing address on file.** It is your responsibility to keep your contact information updated.

Revocation of Authorization

We take the security of your credit card information seriously and comply with all applicable laws and regulations regarding data protection. You have the right to revoke this authorization at any time by providing written notice to Endodontic Excellence of Reston.

Acknowledgment & Consent

By signing below, you acknowledge that you have read and understand this financial policy. You agree to the secure storage of your credit card information and the outlined terms regarding payment responsibilities.

Patient Name: _____
Signature of Patient or Legal Guardian: _____
Date: _____