Metropolitan Dental Specialists
Tannaz Poursaeid, DDS
19735 Germantown Rd. Suite 250
Germantown, MD 20874
Phone (301)972-3311 Fax (301)972-1822

Financial Arrangements, Dental Insurance, and Confirmation Policy

We are committed to providing you with the best possible dental care. Payment for services is due at the time the services are provided. We accept cash, checks, MasterCard, Visa, American Express, Care Credit, and Discover. We urge patients to meet with our Financial Coordinator to discuss financial arrangements prior to treatment to avoid any misunderstandings.

If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and are usually covered close to the maximum allowance determined by each carrier. You are responsible for any balance not covered by your insurance company.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are also responsible for any deductibles not met, any amounts over your yearly contract allowance and co-payment amounts.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges for services rendered are your responsibility.

I understand that regardless of my insurance, I am responsible for the balance on my account for the professional services rendered. I also agree that if I do not pay my account balance within 30 days, I will be responsible for any interest due (1.5% per month), any court costs and attorney fees (15% of my balance due).

I also agree to follow Dr. Poursaeid's office to keep my signature on file giving her office the authorization to submit information on my behalf to my insurance carrier. I also authorize my insurance carrier to pay the benefits directly to Dr. Poursaeid's office.

I understand and agree that I am responsible for keeping my dental appointments. If I need to change a dental appointment, I will give the office 48 hours notice of my need change. If I do not give Dr. Poursaeid's office 48 hours notice of my need to change an appointment, I understand that I will be charged $50 for each ½ of missed appointment time. The advance notice allows us to schedule other patients for their needed dental treatment.

Name of Patient (Please Print): _____

Name of Person Responsible for Payment if not the patient: _____

Signature: _____ Date: _____