MICHAEL O.
McMUNN DDS
and ASSOCIATES, PC
Creating healthy smiles

Payment Policy

I understand that I am fully responsible for payment of any and all services rendered to me by Michael O. Mc Munn, D.D.S. and Associates. I give permission for you to file my insurance to my dental insurance company (if applicable) and authorize the release of any medical information necessary to process my claims. I understand that if I have dental insurance, you will file it as a courtesy to me and that assignment of benefits may be made to your office. I further understand that you will bill me or notify me of any balances on my account that are the result of insurance deductibles, co-payments, partially covered or non-covered services, or if I have no dental insurance at all. My account will be considered to be delinquent if there is a balance remaining after 60 days from the initial billing. If my account becomes delinquent, it may be referred to an attorney or collection agency for collections. I understand that I will be responsible for payment of all costs of collection, including attorney's fees, equal to 33% of all sums due and payable and interest on the outstanding principal balance of 18% per annum. There will be a $25.00 service charge for returned checks and I agree to pay these costs should they occur.

Signature of Patient or Guarantor__________________________________
Date______________________________

Witness____________________________

Or

Signature of Parent or Guardian (if patient is a minor)_______________________
Date______________________________

Witness____________________________

Revision Date 6/06

8804 Patterson Avenue Suite 100 Richmond, Va 23229
Tele: 804.740.7212 Fax: 804.741.6009 www.drmcmunn.com