



3705 Old Norcross Rd, Suite 300
Duluth, GA 30096

Welcome to our practice! We appreciate the trust you have placed in us!

Financial Policy Acknowledgement

*****INITIAL AFTER YOU HAVE READ EACH PARAGRAPH*****

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care that we provide. We continue our commitment by offering a variety of financial option to enable you to receive the dental care you need. We accept cash, check, visa, MasterCard, Discover, and American Express. We have also partnered with a third party company, CareCredit, to offer the flexibility of deferred interest and extended payment options. _____

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of the treatment. A delinquent account impedes our ability to provide you with the quality of dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered. _____

Records Fee: You may(can) request a copy of your records at any given time for a processing fee of \$25. If X-rays are requested, fee may vary depending on the type of x-rays needed. Please allow for 24 - 48 hour time window for processing & electronic delivery. _____

Check Policy: If your check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of \$60.00. _____

Appointment Policy: We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of \$40. You will receive friendly appointment reminders via Email or text notifications that will kindly request to confirm your scheduled appointment. Please be aware that a **confirmation is required** to keep your appointment. Should you find it necessary to reschedule an appointment, please provide us with a notice of two business days to avoid being charged a missed appointment fee. If you repeatedly miss scheduled appointment, you may be asked to pursue treatment elsewhere. _____

Extensive Appointments: Please be advised, If your appointment consists of 2 hours or more you will be required to pay 50% of your total out-of-pocket expense fee for the procedure, at the time of scheduling your appointment or at least a week prior to scheduled appointment. If you are using your Insurance benefits to assist you with your treatment cost, then the full co-insurance amount will be due at time of scheduling your appointment as a deposit. If you fail to come in for your appointment or do not give the required notification for cancelations, then the amount given as a deposit will be forfeited and not be refunded and cannot be applied to future treatment. _____

Insurance Policy: *As a courtesy* to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at that time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of pocket expense. Our office will not enter into a dispute with your insurance company over your claim. The amount you are responsible to pay on the day of service is **only an estimate** based on the information provided by your insurance company. If, at the end of the 60 days, your insurance company has not paid, you are responsible for the entire balance remaining. Also after your insurance has rendered payment you will be billed for any balance remaining. We are participating providers in the PPO network; however, we do not participate in any HMO or DMO networks. _____

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your current coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you. _____

*****Important Facts About Your Dental Insurance*****

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice in treatment. _____
- It is your responsibility to understand the type of dental insurance that you have (i.e. , Traditional, PPO, DMO, or HMO), and the benefits selected by you and/or your employer. _____
- You, not the insurance company, are responsible for the fees of services rendered. _____

I HAVE READ & UNDERSTAND THE STATEMENTS OUTLINED ABOVE.

Patient's Name: _____ Date: _____

Patient/Parent/Guardian's Signatue: _____

**PLEASE BE ADVISED THAT THESE TERMS AND CONDITIONS ARE
SUBJECT TO CHANGE WITHOUT WRITTEN NOTICE.**