OFFICE FINANCIAL POLICY

In order to run our office in an efficient, effective manner, we have developed some policies for the management of our patient's financial responsibilities. Please take a few minutes to familiarize yourself with our guidelines. We encourage your questions and comments.

APPOINTMENT POLICY

We see all patients on an appointment basis, doing our best to see all patients on time. We request that you arrive promptly for the time we have reserved for you. If, for any reason, you need to make changes to your appointment, we require a **48-hour notification call** during business hours, so this time may be offered to another patient. We do understand that unforeseen circumstances arise. In the event that we do not receive 48 hours notice prior to a scheduled appointment or an appointment is missed for any reason without notifying our office, you will be charged a fee of **$50.00.**

PAYMENT OPTIONS

Payment is due the day service is rendered in all instances, unless other arrangements have been made in advance. We accept cash, check, MasterCard, Visa, American Express, and Discover. Non-insured patients who pay in full by cash or debit card on the day of their initial service (if multiple appointments required) will be extended a 10% discount. **We also offer financing options through Care Credit, a third party financing company with up to 18 months interest free plans.** Care Credit is a convenient, low minimum monthly payment program for your entire family specifically designed to pay for healthcare and elective treatment not covered by insurance. Patients who qualify will have the ability to pay over time with no interest if paid in full within the promotional period.

PATIENTS WITH DENTAL INSURANCE COVERAGE

Payment of your estimated portion of your treatment is due the day service is rendered. Dental insurance is designed to assist patients with their dental needs. It is not intended to be for complete coverage for all treatment. Not all plans are the same. The extent of your benefits depends on the quality of the plan purchased by your employer. We can attempt to find out your maximum and your deductible, but it is ultimately your responsibility to become familiar with your own plan. **To make sure that you receive the best care for your individual condition, the treatment suggested to you will be based on your dental needs. It will not be dictated by your insurance company and their limited coverage.**

SOME GENERAL PAYMENT AND INSURANCE GUIDELINES

*Please be sure to know your insurance company's name, address for claims, phone number, and group number. To accurately check your insurance benefits and file your claims we will need your personal identification number or social security number, whichever applies to your specific insurance plan. Please be sure to advise us if this information changes at any time throughout the year, so that we can update our records.

***You are ultimately responsible for the entire fee regardless of the portion covered by your insurance**. Insurance coverage usually ranges from 50% to 90% of the treatment fees. We will do our best to present you with a treatment plan estimate; however, it is only an estimate and not a guarantee of payment by your insurance company.

*We will do our best to collect payment from your insurance company. **If a claim is denied, downgraded, or uncollectible for any reason, any portion not paid by your insurance company will be your financial responsibility.** If your insurance company sends you the check for services you received, you agree to endorse the payment to All Smiles Atlanta immediately. This is money that is rightfully owed to the doctor for services received. If you cash the check and keep the money, and do not pay your bill, the practice reserves the right to pursue legal action.

*__The services for the treatment of minors are the responsibility of the adult accompanying the minor to the appointment.__

*Checks returned unpaid from the bank are subject to $35.00 service fee.

(policy continues on back)

Patient Initials: _______________ **Date:** ______________

I have read, understand and agree to adhere to the office and financial policies outlined above.

Agreement to Pay:

I authorize the provider and staff to release any information required to process insurance claims. I understand that any portion not paid by my insurance company will be my financial responsibility. **There will be a 1 1/2 % per month (18% per year) finance charge on balances unpaid after 60 days. Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.** If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I understand that I will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting on my account.

______________________________________ _______________________

Responsible Party Name (Print) **Date**

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Responsible Party Signature

Contact Policy:

You agree in order for us to service your account or to collect monies you owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or emails, using any email address you provide to the office.

I have read this disclosure and agree that All Smiles Atlanta Dental Spa, its employees and/or agents may contact me as described above.

______________________________________ ___________________________

Responsible Party Signature **Date**

We welcome you to our office and look forward to helping you achieve the healthy, beautiful smile you deserve!