Patient Financial Agreement Form

Patient Name:_____

We are pleased to welcome you to Dunwoody Dental Care. Our desire is to provide you with the highest quality dental care using only the best material and technology, in a relaxed and informative environment. We pride ourselves in ten simple principles in our office. We hope that your experience here is a result of our principles; Trust, Honesty, Communication, Integrity, Growth, Acceptance, Encouragement, Dignity, Excellence and Humility.

The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT
I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge.

I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier.

I authorize the assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patients Initials_____

FINANCIAL RESPONSIBILITY
I understand that PAYMENT IN FULL is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. **We no longer do monthly payments**, unless you are in Orthodontic treatment. We do offer CareCredit. For more details please ask.

WE ACCEPT CASH, PERSONAL AND BANK CHECKS, AS WELL AS ALL MAJOR CREDIT CARDS **(WITH A 3% SERVICE FEE)**. Returned checks will be charged a $35.00 NSF fee on the patient account.

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

Patient Initials_____

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a **COURTESY**, we will submit the fees for your treatment to your insurance company on your behalf. However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment. We will attempt to gain as many benefits as possible from your insurance for the services provided but your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept the assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient. If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any 'patient portion' not covered by insurance, which will be due at the time of service. Please be advised, this is an **ESTIMATE** and not a promise or guarantee of coverage from the insurance carrier.

RELEASE

I consent to clinical examination and the making of video, photographs, and x-rays before, during, and after treatment, and in scientific papers or demonstrations. I certify I have read, or had read to me, the contents of this form and realize the risks and limitations involved.

All new patient emergency appointments will be charged upfront, payment in full at time of service. Any prepaid amounts will be reimbursed upon receipt of insurance payment.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

_____ _____

Patient Signature Date