DENTISTRY AT SUWANEE

Financial Policy

We appreciate the value of your time and strive for on time appointments. Our goal is to give each patient the personal & individual attention you deserve for each & every appointment**.** We work by scheduled appointments and ask that you make every possible effort to be on time for the appointment we have reserved especially you. We ask that you give a **48 Hrs Notice if you find it necessary to cancel or reschedule** your appointment, **or a Broken appointment fee of $50 (per hour for Dr's time) may be assessed**.

First missed appointment: We will give you a verbal reminder of our office policies

Second missed appointment: Written Notice with a statement of the charge posted & billed to your account

Third missed appointment: Showing a lack of commitment for your dental health and our providers time, may lead to being ask by our office that you seek another dentist for your dental treatment.

Please be courteous & call as soon as possible, you may also leave a message on our night recorder

FINANCIAL OBLIGATIONS

Service is due/payable on the day services are rendered in our office, unless you have made prior arrangements with our office. As a courtesy, if you have dental insurance, we will accept the assignment of benefits and ask that you pay only the **estimated portion** on that day. **Be aware that the estimated amount is only an estimate (not a guarantee) by our office that is figured by information we have collected by phone/fax from your insurance. You will be fully responsible and billed for ANY REMAINING BALANCE after the insurance has paid benefits.** Should the insurance benefit check be sent to you, you will need to pay us immediately.

Please be aware that we will make every effort within our means to help you file for your benefits , but you are responsible for monitoring your dental insurance benefits and that the responsibility for your account balance is ultimately yours. **(Regardless of the insurance; we file your claims as a courtesy to you)** Should your account balance become 90-days PAST DUE, regardless of the insurance, the account balance will need to be Paid or may be turned over for collection; which you will then have additional fees added to your account for collection cost and any court cost and/or attorney fees.

I UNDERSTAND & AGREE: _____ _____

Signature(Patient/Parent or Guardian) Date

By signing, I authorize Dentistry At Windermere, PC to submit my claims electronically & assign benefits to be paid directly to this office. I understand that any claim or unpaid portion of a claim or claims is solely my responsibility & I agree to pay Dentistry At Windermere, PC in full for the services that have been rendered.

CLINICAL CONSENT

_____ I agree to update the medical history & personal information as required for myself & my dependents.

_____ I hereby authorize Dentistry At Windermere, PC to perform any necessary & mutually agreed upon x-rays, study models, Photographs (for diagnostics & identification purposes), or any other diagnostic aids deemed appropriate by the dentist for the sole purpose of proper diagnosis.

_____ Upon such diagnosis, I authorize Dentistry At Windermere, PC to perform any mutually agreed upon treatment, & to employ such assistance as required to provide proper care; including anesthetics, sedatives & others medications as necessary. I fully understand the use of anesthetics agents embodies certain risk. I understand that every precaution will be taken & that I may ask for a complete recital of any possible complications.

Signature: _____ Date: _____

(Patient or Parent/Guardian)