SHAUNA H. MITCHELL, D.D.S., P.C.
3642 FLAKES MILL ROAD, SUITE B
DECATUR, GA 30034

Office Policies

We would like to thank you in advance for choosing our office for your dental needs. Our staff will estimate your co-payment and deductible. The amount the insurance company will pay varies. At the time of your visit, you will be financially responsible for the percentage or portion that is not covered by your dental insurance. Changes in benefits and exclusions, which may be unique to your policy, may result in a refund, or additional balance due after your insurance has paid.

If we have over estimated your benefits, a refund will be sent after your claim has been processed (4-6 weeks). If we have under estimated your benefits, you will be billed for the difference after your claim has been processed. *Missed and broken appointments without 24 hours notice will result in an $85.00 charge.*

We must emphasize that as dental care providers our relationship is with you and not your insurance company. As a courtesy to our patients we will bill your insurance company for you. **If your insurance company has failed to pay within 60 days, we will expect you to pay the balance of your bill in full.** If it is necessary for us to pursue collection efforts against you, you will be held responsible for applicable collection fees. It is your responsibility to provide updated insurance information.

White tooth colored fillings for back teeth are more difficult and time consuming than silver fillings. Therefore, they are a higher fee. Most insurance companies limit their benefits to the lesser fee. The patient will be responsible for the difference.

Consent to Dental Photography

In connection with dental services, I may be receiving from SHAUNA H. MITCHELL D.D.S., P.C. I agree and consent to allow photographs taken.

A full face photo will be taken for identification purposes. This photo will be uploaded into our computer program. Photographs may also be taken of before, during, and after completion of my dental treatments, to be used for dental records, research, education, public relations, patient counseling or other professional purposes. I further agree and consent that the photographs relating to my dental care may be published and re-published either separately or in connection with each other in dental photo albums, professional journals or dental books. My entire face will not be shown unless I give separate written consent. All photographs are the property of SHAUNA H. MITCHELL D.D.S., P.C.

If you have any questions, please feel free to ask us.

Signature_____ Date_____