

DENTAL INFORMATION

Previous Dentist's Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

ACCOUNT INFORMATION

Person responsible for payment of professional services: _____
Address (If different from patient): _____ Apt. # _____
City: _____ State: _____ Zip: _____ Phone: _____

FINANCIAL POLICY

IN OUR CONTINUED COMMITMENT TO PROVIDE THE HIGHEST QUALITY OF DENTAL HEALTH CARE AVAILABLE TO ALL OF OUR PATIENTS AND TO HAVE THOSE SERVICES COMFORTABLY AFFORDABLE, WE HAVE CREATED A FINANCIAL POLICY WITH THE MAXIMUM FLEXIBILITY FOR OUR PATIENTS' INDIVIDUAL NEEDS.

1. CASH OR CHECK

On service \$1000 or more, we offer a 10% discount for amount paid in full with cash or cashier's check, 5% if paid with a credit card.

2. CREDIT CARDS

We will accept MasterCard or Visa as payment for your dental charges as payment in full as services are rendered.

3. INSURANCE BENEFITS

We will as a courtesy, process your insurance claims here in our office which will relieve you of this time consuming and complicated burden. We do require you to pay your deductible and estimated payments at the time of each visit.

IF INSURANCE DOES NOT PAY WHAT HAS BEEN ESTIMATED, YOU WILL BE RESPONSIBLE FOR YOUR ACCOUNT BALANCE HERE. THE BALANCE IS NOT WITH YOUR INSURANCE COMPANY, IT IS WITH THE RESPONSIBLE PERSON ON YOUR ACCOUNT.

4. A convenient line of credit can be arranged for all your dental needs which are administered through Care Credit. You will be required to complete an application and be approved to participate in this payment plan. Care Credit will provide you with a dental line of credit that is similar to your MasterCard or Visa, but with these added benefits to you:

- A. 90 days free interest.
- B. Your existing credit cards remain open for your personal use.
- C. You can make monthly payments.
- D. There are no prepayment penalties if you elect to pay off your revolving dental line of credit.

So that we know which payment arrangement best meets your needs, please circle 1 2 3 4

Insurance can be filed if you sign below releasing information and authorizing assignment of benefits and you agree to pay your estimated portion. If insurance does not pay what has been estimated, you will be responsible for the difference. The doctors cannot be responsible for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature: _____ Date: _____

PERMIT FOR DENTAL SERVICES FOR A MINOR

Signing this permit does not obligate you to accept dental services for your child.

I being the parent / guardian of _____ do hereby authorize and request the performance of dental services for the patient and to do whatever procedures are diagnosed by the dentist that performs the dental examination.

Signed: _____ Relationship: _____ Date: _____

FOR OFFICE USE ONLY

What brought you in to see us today? _____

What is most important to you concerning you or your child's dental health? _____

- a. esthetics
- b. comfort
- c. longevity
- d. function

What's most important to you concerning your relationship with the dentist or dental staff:

- a. trust
- b. friendliness
- c. communication
- d. respect
- e. competence
- f. other

How do you know that _____ is there? _____

Do you make health care decisions based on what is...

- a. POSSIBLE
- b. NECESSARY

Dental Associates of Athens
1005 West Market Street Suite 3
Athens, AL 35611
256-232-1404

Thank you for choosing us as your dental health care provider. We are committed to your successful preventive and restorative dental care. Please understand that the payment of your bill is considered a part of your dental visit. The following is a statement of our financial policy which we require you to read and sign. **FULL PAYMENT IS REQUIRED (OR ESTIMATED INSURANCE PORTION) AT THE TIME OF SERVICE.** If you are unable to pay your estimated portions on each visit, we do offer financing. Our financing here requires an **approved credit check.** There will be a \$2.00 monthly service charge and an 1% interest rate (12% annually) charges to any account with a balance over 90 days old. (interest rate subject to change)

INSURANCE BENEFITS

The balance in our office is your responsibility whether your insurance pays or not. We can not bill your insurance unless we maintain current insurance information. Your policy is a contract between you, your employer, and your insurance company. We are not a part of that contract.

Some companies will accept claims from us, but will send the insurance payment to the employee that is the policy holder. We will file your insurance for you, but your bill is due the day of service. Our charges are in range of what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

It is your responsibility to know your insurance plan and coverage. We give estimates here based on the most recent information that our patients provide us. This information is not a guarantee that your insurance will pay the estimated amount. Please request a pre-determination of benefits if you need to know the "exact" amount your insurance will pay. (This usually takes your insurance company 4-6 weeks).

MINOR PATIENTS

The adult accompanying minors (or guardian of the minor) is responsible for full payment according to the above. We cannot accept assignment on insurance unless the parent or guardian signs the information sheet as the responsible party. We do not work through divorce agreements or court judgements. If you bring a minor for an appointment, you will be held responsible for the account here. We will provide you with the receipt to collect your money for the responsible party.

APPOINTMENTS

Patients are seen on an appointment basis. Please make an appointment for all visits. A broken appointment prevents us from taking care of someone else. Please inform us **24 hours in advance** if you are unable to keep your appointment. We reserve the right to charge for appointments cancelled or broken without a 24 hours advance notice.

I will be responsible for any interest on my account if my account balance is over 90 days. I will be responsible for any legal fees and collection charges if my account is delinquent.

I have read, understand, and agree to this financial policy.

Signature of patient/ parent/ guardian _____

Date _____ Social security number _____

