OFFICE/PATIENT AGREEMENT

NORTH ATLANTA CENTER FOR COSMETIC AND IMPLANT DENTISTRY, P.C.

I. PAYMENT FOR TREATMENT

The best patient-doctor relationships are maintained with an understanding of the treatment rendered and the associated fees. Our fees are based on a reasonable assessment of services provided, the required expertise, and the time required to complete treatment. Please feel free to discuss treatment options and/or fees with us at any time. **Please note that payment in full is expected when services are rendered.**

II. INSURANCE

At the time of treatment, if you would like us to file a dental insurance claim, you will be required to pay the insurance deductible portion and the **estimated** amount not covered by your insurance while **providing a credit card to be kept on file**. If for any reason your insurance provider has not remitted payment within twenty-one days from the date of services rendered, regardless of the delay, your credit card on file will be charged for the outstanding balance in full. Payments that are dishonored by the credit card company will result in a finance charge of 5% of the outstanding balance plus a reprocessing fee of $25. After your card has been charged and the balance paid in full, any future payments made by your insurance company for these services will be forwarded to you upon receipt. Although we may file an insurance claim for you, we have no knowledge of the terms, conditions, or exclusions of your individual contract. We do not maintain contractual relationships with any insurance company. We will estimate your insurance coverage, but even with an insurance payment, you may still have an outstanding balance. We will try to assist you in filing with your insurance company, but the responsibility to pay for our services remains with you. **You are responsible for all fees regardless of whether insurance pays.**

III. CANCELLATIONS/ BROKEN APPOINTMENTS

Our office is open Monday-Thursday from 8:00 am to 5:00 pm. The community has recognized the uniqueness of our office in providing excellent dental care, which has created extraordinary demands for time efficiency. Your failure to arrive on time, or not at all, impacts not only our staff but our other patients as well. Because you are requesting our time when you reserve an appointment, we reserve the right to charge for any broken or cancelled appointment without a **WORKING 2-DAY** notice, regardless of the cause. The full fee of the appointment will be charged to the credit card on file and receipt will follow in the mail. Please note that if you need to cancel an appointment for Monday, it must be cancelled before close of business the Wednesday of the prior week; to cancel an appointment for Tuesday, it must be cancelled before close of business the Thursday of the prior week; to cancel an appointment for Wednesday, it must be cancelled before close of business on Monday of that week; to cancel an appointment for Thursday, it must be cancelled before close of business on Tuesday of that week.

IV. COLLECTIONS

A. Credit Card “Charge-Backs” and Delinquent Accounts: Any account requesting a “chargeback” and/or any account over 30 days will result in 16% interest on the full balance owed. Unpaid accounts will be turned over to our collections attorney. Patient/Guarantor shall be responsible for any and all incurred expenses required to bring the account current, including but not limited to, court costs, $250 of attorney fees, and any administrative fees required to settle the account.

B. Bounced Checks: The balance of the check amount and/or the full account balance plus a $35 bounced check fee to cover bank costs and administrative fees will be charged to the credit card on file. A receipt will be sent in the mail following the notification and transaction.

C. Any action or proceeding brought by parties under or relating to this Agreement shall be brought in a Magistrate or State court located in Gwinnett County Georgia. Patient hereby irrevocably submits to the personal jurisdiction of Gwinnett County and irrevocably consents to venue in said courts for purposes of any such action or proceeding. This Agreement will be governed by and construed in accordance with the laws of the State of Georgia.

My signature below verifies that I have read, understood and agree to the terms of the above.

SIGNATURE: ____ DATE: ______________________

PRINT NAME: ____