Family & Cosmetic Dentistry
Dental Smiles
At Dacula

Financial Policy/Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

A service charge of 1.5 % per month on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon. Any overdue balances may be considered for further collection activity and credit reporting.

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient's Responsible Party understands that Dentecare Dental LLC, DBA Dental Smiles at Johns Creek has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or patient's Responsible Party understands that they are responsible for all cost of collection including but not limited to, interest due at the 1.5% per month or 18% APR, all court costs and Attorney fees, and a collection fee of 25% will be added to the outstanding balance.

You will need to request in writing and pay a reasonable administrative fee of $25/patient if you want to have copies of your records.

I understand that the fee estimates for dental care can only be extended for a period of 30 DAYS from the date of consultation.

When Insurance Is Involved:

If you have insurance that has dental coverage, as a courtesy, we will file insurance benefits for you. Prior to starting any treatment, we will provide you with a cost estimate indicating our total fee, what we expect insurance coverage to be, and your estimated financial obligation due on the day of service. This figure is only an estimate. Additional billing or refunds may be required. Any changes will be brought to your attention as soon as possible. Many insurance companies will pay our office directly. However, some insurance companies may only reimburse you and not our offices. If your insurance company will not reimburse our office, you will be responsible for the full cost of the visit. Your insurance company will send you a reimbursement check directly. We will allow a maximum of 45-days for your insurance company to clear all account balances. Any unpaid portions will be due in full by you after this period. After attempts to collect outstanding funds and a 90-day grace period from time of service, patient, parents or guardians not fulfilling their financial obligation will be sent to collections and credit reporting.

When insurance is not involved:

Payment is due when the services are rendered. All financial arrangements must be made in advance. Any overdue balances may be considered for collection activity and credit and credit reporting.

FORMS OF PAYMENT:

Our dental office accepts accepts various forms of payments in the form of cash, credit cards (Visa, MasterCard, Discover), Debit Cards and also offers Care Credit or similar patient healthcare financing for dental treatment. However, we do accept cashier's check or money order made out to "Dental Smiles At Johns Creek."

Due to large amounts of bad checks, we do not accept personal checks as a form of payment for dental services.

BROKEN APPOINTMENT POLICY:

I understand that a 24 hour business day notice is required for changing or canceling the dental appointment.

If the appointment is confirmed and broken without a 24 hour business day notice, dental office reserves the right to charge $50 for every hour of scheduled broken appointment. For more than 3 rescheduled, we may require a non-refundable deposit of 50% upfront before making any appointments.

If you are coming through LHI: I am aware that I am coming through LHI and so the above mentioned financial responsibility doesn't apply to me since it is preauthorized by LHI and the responsibility is taken by LHI. By signing below, I am assigning the benefits to be collected through LHI by Dental Smiles at Johns Creek, Dr. Devang Shah and associates.

I grant permission to you and your assignee, to telephone me to discuss matters related to this form.

I authorize Dental Smiles at Johns Creek/ my dentist to release information from my dental/medical record to my insurance carrier or government agency for the processing of claims for dental/medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Dental Smiles at Johns Creek/ my dentist, on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Relationship to Patient: