

Dental Smiles At Suwanee

2133 Lawrenceville Suwanee Rd

Suite 13

Suwanee GA 30024

(678)377-6453

mail@dentalsmilesatsuwanee.com

www.dentalsmilesatsuwanee.com



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.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, this office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

I understand that the copayment or patient (my) portion of payment is only an estimate and I will be responsible for any balance after the insurance payments are made.

A service charge of 1.5 % per month (18% per annum) 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.

You will need to request in writing, and pay a reasonable administrative fee 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.

FORMS OF PAYMENTS:

The dental office accepts various forms of payment 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 Suwanee".

Due to a 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 notice is required for changing or cancelling the dental appointment.

If the appointment is confirmed and broken without a 24 hour notice, the dental office reserves the right to charge \$40 for every hour of scheduled broken appointment.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing, unless a payment plan is setup in advance; if credit is extended.

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I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

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

Signature of guarantor of payment/responsible party:

Signature: _____

Date:

Relationship to Patient:

Response Date: