CREATIVE DENTISTRY of Atlanta
5505 Peachtree Dunwoody Road, Ste 460
Atlanta, GA 30342
404-883-3287 (phone)
404-883-3287 (Fax)

Office Policy and Procedures

We are committed to providing you with the best dental care possible within a safe and trustworthy environment. Our office policy and procedures reflect our commitment to professional excellence. If you have dental insurance; we are obliged to help you receive the maximum benefits allowed. We request your assistance and understanding of our office and payment policies in order to achieve the best standard of respectful service.

A. Payment in full is expected when services are rendered. We gladly accept the following forms of payment: Cash, Money Order, Visa, MasterCard, Discover, American Express and Care Credit. Financing is available through Care Credit. Should you need assistance with applying for these services please see one of our office staff for assistance.

B. For patients with insurance, ***you are ultimately responsible for any balance for services.*** Insurance will be submitted as a courtesy. We estimate all co-pays according to the breakdown given to us by your insurance company. **This quote is not a guarantee of payment.** The final determination is done after the insurance company receives the claim. We gladly accept insurance assignments, but require that the deductible and the entire co-pay be paid when treatment is rendered.

C. **As a courtesy to our patients, we will file primary insurance. We do not file secondary insurances.** Filing claims to secondary insurance is the sole responsibility of the insured. We can give you a copy of the claim one time at no charge. Further claims will be a charge of $5.00 per claim.

D. If payment from your insurance company is not received within *five (5) weeks* after the completion of treatment, you will be expected to pay for all dental services. You can help insure timely and accurate payment from your insurance company by providing accurate information needed to process the claim. *If you come in and have treatment rendered after your insurance coverage is terminated, you will be charged a $50.00 filing fee.*

E. We do offer 1 TIME *pre-estimates* and *pre-determinations* based on the benefits provided by your insurance company.

F. Please be aware that not all services are a covered insurance benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover.

G. The investment necessary to complete your treatment is an estimate based upon information gained from the doctors' examination and radiographs. Should additional problems arise as treatment progresses, the estimate may have to be revised. .

H. For all major dental work, we require a *minimum* deposit of 30% of co-pay amount, which will be applied to the cost of your procedure. This will enable us to reserve the allotted time with the doctor and hygienist.

I. You may jeopardize payment of your insurance benefits if you do not receive treatment in the proper sequence or in the recommended time frame or if you fail to complete the treatment plan. Either situation may create the need for re treatment or additional treatment, resulting in

additional charges to your treatment plan case fee.

J. **A 48-hour cancellation notice is required for appointments.** There will be a *minimum* fee of $50.00 assessed for the appointments cancelled same day or not cancelled within 48 hours of scheduled appointment.

K. **Record requests** (request of x-rays and/or records) are subject to a 24-48 hour response time. Our office requires written notice to have all records transferred.

L. Local anesthesia and nitrous are considered a separate charge from the actual procedure, and will be billed to the insurance as such. The patient is responsible for all anesthesia charges that the insurance does not cover or considers being part of the actual procedure.

M. Balances must be paid in full before any future appointments can be made or services can be rendered.

N. Our billing cycle is every 30 days. After the first statement or 30 days, if the balance is not paid, a 10% finance charge will be added to your account. After the second statement or 60 days, if the balance is not paid, a 30% finance charge will be added to your account. After the third statement or 90 days, if the balance is not paid, a collection fee of $50.00 will be added to your account and the account will be turned over to a collections agency. If your account has been turned over to a collection agency, you must contact them to settle your account.

O. The client will pay attorney fees and collection fees incurred in an effort to collect payment stipulated by this agreement.

P. Failure to sign a service contract does not negate the responsible party from financial responsibility for any services that have been rendered since submission to treatment implies consent as outlined in this service agreement.

Q. Because patient visits are confidential, the use of cameras, smart phones with camera access, recorders or digital recording devices are prohibited within operatories and/or all clinical treatment areas.

We do realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our office promptly for assistance in the management of your account.

I have read and agree to the office policy and procedures set forth by Creative Dentistry of Atlanta . I understand that the office policy can change at any time without notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Office Policy and Procedures

Signature ____

Date____

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