Office Policies

Dental Insurance Policy

All consultation appointment fees are due the day of your appointment. We will file your insurance claim for your reimbursement.

You are responsible for all estimated co-pays and deductibles when treatment is rendered upon receipt and verification of your dental insurance information. (If we cannot verify your insurance, you are responsible for the total fee). The estimate is based on information given to us by your insurance carrier. You are responsible for any balance your insurance does not cover. We will file your insurance claim and allow them 45 days to render payment. After 45 days, you will be responsible for the entire balance.

Dental plans with out-of-network benefits are accepted at this office. Our office does participate with a few PPO insurance plans. Please call our office for verification. We do not file secondary insurance claims for payment to our office.

Treatment due to trauma is usually covered under medical insurance. Due to delays in receiving payment, we do not file medical claims. We will provide you with any documentation needed for you to submit a claim to your insurance carrier.

Payment Policy

For your convenience our office accepts all major credit cards, cash and local checks from local banks with a valid Georgia ID. We do not accept out of state checks. There will be a $30.00 fee for returned checks.

If you require an extended payment plan, we are pleased to offer CareCredit which has a six month no interest plan and extended plans with interest. This is an independent outside credit source and requires approval through them by telephone or internet prior to your treatment.

Appointment Policy

Our office will attempt to confirm your next appointment within 48 hours using the phone number(s) and/or email you have provided. However, it is ultimately your responsibility to confirm your next scheduled appointment with our office. If this next appointment has not been confirmed directly with our office, it will be given to another patient. An additional fee will be charged for appointments broken without 24 hours advanced notification.

I have read and acknowledge the insurance, payment and appointment policies stated above.

Patient/Guardian's Signature: ____ Date:__________________

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AAE American Association of Endodontists
SPECIALIST MEMBER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name of Patient/Guardian: ____

Signature: ____ Date: _______________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining Acknowledgement
- ☐ Other (please specify)