Complete Dental
Where we Complete your Smiles

Office Policies, Procedures and Patient Authorizations

Payments: Complete Dental of Suwanee accepts payments in the form of cash, personal/company checks, money orders and credit cards **Initials_____**

Insurance:

If you have insurance, we will be happy to file your insurance claims as a courtesy. However you will be responsible for your deductible and coinsurance at each visit. Our computer software makes an estimate of what your insurance will cover and estimates what your "out of pocket" portion. This is only an estimate and it is possible that your insurance may cover less than what is estimated. If this should happen then the remaining balance will be your responsibility to pay. **Initials_____**

Interest Fee Payment Options:

We do offer interest fee payment options through Care Credit Financing. This is a company not affiliated with Complete Dental Of Suwanee and we do not have any control over acceptance in these programs. We will assist you in the application process as much as we possibly can. **Initials_____**

Financial Arrangements:

Financial arrangements may be possible. They must be made in advance, before any treatment has been rendered. Financial arrangements at discretion of Complete Dental Of Suwanee and will be handled on a case basis. **Initials_____**

Full Payment Discount:

We do offer a discount on cash payments made for the full amount of the service and being paid at the time of service for non-insurance patients. These discounts are not applicable with the use of any other offer or coupon. **Initials_____**

Finance Charges:

Accounts that have had a financial arrangement made or that carry a balance from one billing month to another will incur a 5% monthly finance charge on the carry over balance. **Initials_____**

Delinquent Accounts:

We will consider an account delinquent when the balance goes unpaid in 90 days without a financial arrangement in place or on accounts with financial arrangements that have defaulted on the agreed upon financial arrangement. Accounts in one of the two before mentioned conditions may be turned over to an outside collections agency for handling. A patient whose account has been turned over for collections will be responsible for all collection and court cost associated with this process. Patients who had their account turned over tp collections will no longer be considered active in the dental practice and will only be seen on a cash basis once the balance has been taken care of with collection agency.

Initials_____

Return Check fee:

If payment is received in the form of check written by the patient or on behalf of the patient, it is considered that the patient's will be charged a return check fee in the amount of $35.00. It is also understood that any payments made to Complete Dental of Suwanee will need to be in the form of cash credit card or money order. **Initials_____**

Authorization to File/Collect Insurance:

I the patient here by give my authorization for financial office of Complete Dental OF Suwanee to affix my name to any and all claims or documents related to and needed for the processing of insurance/ health benefits on my behalf. With this I am also authorizing the payments of such benefits to be made directly to Complete Dental Of Suwanee**.** **Initials_____**

Authorization for Treatment:

I the patient hereby give my authorization to the dentist and team members of Complete Dental Of Suwanee to render dental treatment to me that the judge to be beneficial to my oral and overall health. In giving this authorization it is understood that my dental condition will be explained to me and options for treatment options. It is understood that I have the right to refuse any treatment options presented. However with refusal of treatment it is also understood that the dentist at Complete Dental Of Suwanee have the option to refuse further treatment and even dismiss me from the practice when such refusal of treatment is seen as detrimental to my future dental health, or compromise the professional ethics of the dentist. **Initials_____**

I HAVE READ AND UNDERSTOOD THE ABOVE POLICES AND PROCEDURES, I GIVE THE ABOVE AUTHORIZATION FOR TREATMENT TO **COMPLETE DENTAL OF SUWANEE**

PRINT PATIENTS NAME: _____

PATEINT SIGNATURE: _____ DATE:_____

I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND REVIEW, AND UNPON REQUET GIVEN A COPY OF THE PRIVACY PRACTICE POLICEIS.

I HAVE ALSO GIVEN MY PERMISSION FOR MY MEDICAL AND PERSONAL INFORMATION TO BE SHARED WITH THE FOLLOWING INDIVIDUALS ON MY BEHALF.

NAME:_____RELATIONSHIP TO PATIENT :_____

(if no individuals are listed above, we will only share your medical/personal information when pertinent with other Dental or Medical Professionals with whom we are referring care to if needed. This information will also be used only as needed when submitting your insurance claims on your behalf.)
PATIENT/RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____