



OFFICE POLICIES

OUR office policies are designed to provide structure for our office so that we provide good consumer service and ensure that all patients receive the same quality service and treatment. We strive to make sure that your experience with us is a good one.

Thank you... for taking the time to read and complete this form. It will enable our office to be more effective in meeting your needs. If you have any questions at anytime, please ask us, we will be happy to help.

...The Doctors and Staff of Roberts Family Dental, P.C.

- 1. Informed Consent for Treatment:** I hereby, give consent for the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of our dental needs. Upon such diagnosis, I authorize doctor to perform the recommended treatment agreed upon by us and to employ such assistance as required to provide proper care. We agree to the use of anesthetics, sedatives and other medication as necessary. We fully understand that using anesthetic agents embodies certain risk. We understand that we can request a complete recital, prior to the start of the anesthesia, of any possible complications related to our treatment. I confirm that the information we provided today is complete to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the doctor of any changes in my medical/dental/financial/personal information. _____ (Initials)
- 2. Our Federal Truth in Lending Disclosure Statement:** In order to comply with the "Truth in Lending Act" and the requirements of Regulation Z, we are required by law to retain a signed copy of any payment schedule in our file, even though no interest or carrying charge is included in the payment amounts. The payment schedule used by Roberts Family Dental, PC is referred to as a Financial Agreement (*herein referred to as an F/A*). If treatment is interrupted or discontinued, either party may initiate renegotiation of this agreement. Responsible Party also has the option of paying the balance off before the date stated in the F/A. There will be a late fee of \$50.00 per month for any payment that is more than 30 days late. _____ (Initials)
- 3. Authorization to Release Personal, Medical, Dental or Financial Information:** As the **Guarantor/Insured Party** (*herein referred to as I/our/us/my*) of this account, and for anyone enrolled under or added to this account, I hereby authorize Roberts Family Dental, P.C. or a professional entity affiliated with them, to give the health plan/insurer; the collection/legal agency and the employer or any of their designees, any and all records or information pertaining to Our personal, medical, dental or financial history. For services rendered to us, for any administrative purposes, including evaluation of an application or a claim, for any collection process in the case of default of payment for services rendered and/or for any analytical or research purposes. I also authorize on behalf of us, the use of a social security number for purpose of identification. A photocopy of this authorization will be as valid as the original. _____ (Initials)
- 4. Our Payment Policy:** Payment for services rendered is due at the time of service, unless prior arrangements have been made. We accept MasterCard, Visa, Discover Card, American Express, Cash, Checks and ATM debit cards. Patients who request credit card **charge backs** for any reason will be billed **\$100.00 per charge back** in addition to the original charges for services provided by our office. A current Georgia Driver's license or picture id is required. Patients are responsible for payment in full for services rendered to them. In order to accommodate the needs and requests of as many patients as possible, we will explain your financial obligations to the best of our ability, prior to treatment. It is a policy within this practice, that in the event payments are not received as agreed upon, a 1-1/2% late charge (18% APR) may be added to Your account. Payment is due at the time of the service. Patients are responsible for all costs/fees associated with collections on their accounts incurred by Roberts Family Dental, PC for collections. **Remember that you, the Patient/Responsible Party/Guarantor, are ultimately responsible for payment of your account.** _____ (Initials)
 - **Please make checks payable to: Roberts Family Dental**
 - **We do not accept out of state personal checks or third party personal checks.**
 - **There is a \$50.00 charge on all returned checks.**
- 5. Statement:** A detailed itemized receipt is given to each patient at the end of their appointment. Please do not hesitate to request a printout, if one is not generated for you. _____ (Initials)

6. Our Insurance Filing Policy: As an added courtesy for our insured patients, Roberts Family Dental, P.C. will file claims to your insurance company on your behalf, based on the information given us at the time of service. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Therefore, in the event that you do not agree with your insurance companied assignment of your benefits, you are responsible for appealing their decision. **It is the insured person's responsibility to understand their benefits.** _____ (Initials)

If you have a PPO, POS or Indemnity Insurance Plan, part of our service is to provide you with an estimate of your insurance benefits, based on the information given us at the time of service. If you are unsure of your benefits and/or don't agree with the estimate given, please reschedule your appointment until you are able to verify your benefits. **Insurance companies generally do not cover cosmetic procedures.** _____ (Initials)

7. Our Appointment Policy: Our appointment schedule is designed to respect your time and convenience as well as efficiently utilize our facility. If you are late for an appointment you may be required to reschedule your appointment. Depending on the time required for your procedure, you may be seen, however note that in order to avoid delays for other patients who have appointment, your appointment may take longer than originally planned and you may have to wait to be worked into the schedule. Sometimes there are unavoidable delays. If you have been waiting for more than 30 minutes and one of our staff members has not spoken to you concerning your appointment, please return to the front desk and ask for assistance. _____ (Initials)

A broken appointment is a loss to everyone. If you need to change or cancel your appointment, we would greatly appreciate at least a 24-hour notification, to afford us time to possibly give that reservation to another patient. Your cooperation will allow us to better serve our patients. We provide a 24 hour answering service, so that you may leave a message for the office if you are unable to reach us during normal business hours concerning your appointment. _____ (Initials)

There is a **\$25.00 cancellation fee** for patients who do not cancel their appointment prior to a full 24 hours. Please call as soon as possible to let us know if you cannot keep your appointment. In order to provide better service to our patients we do not overbook to compensate for no shows therefore we must bill for missed appointments. If we are able to fill the appointment slot with another patient the cancellation fee may be waived. _____ (Initials)

8. Our Medical Records Copying Policy: There is a **\$15.00** copying fee for medical records plus postage. You must sign a medical release form and pay the copying fees before records are sent out. Medical records are sent out within 14 days of a completed request. _____ (Initials)

9. All product sales are final. Patients are responsible for payments for products sold in our office. No refund will be given once a product has been purchased and taken from the office. There are no refunds on products sold in our office for any reason. Please do not ask the staff or doctor for refunds once you have purchased a product. _____ (Initials)

10. Our Discharge Policy: We reserve the right to immediately discharge a patient from our practice if a patient is abusive to the staff or refuses to follow our office policies. _____ (Initials)

Guaranteed Intent to Pay: As the Guarantor/Insured Party (*herein referred to as I/us/my*) of this account, and for anyone enrolled under or added to this account, I hereby, guarantee payment to the office of Roberts Family Dental, or a representative of, Roberts Family Dental, for services rendered by the doctor and/or his agents; to us. I understand the doctor is acting in good faith by agreeing to perform said services prior to payment and this acts as my guarantee to pay the doctor in full for all services rendered.

As the Guarantor of this account, I have read and understand the office policies as stated above and agree to accept financial responsibility as described, for all services rendered, and for anyone enrolled under or added to my account in full for all services rendered.

It has been explained to me, and I understand and I agree, that I am responsible for the entire Professional Fee, including any portion of the Estimated Insurance Benefits amount (if any) that is not paid by insurance. I also understand that there will be additional charges for broken or and for missed appointments. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (*18% APR*) may be added to my account.

By signing below I acknowledge that I have read this document and agree to abide by the office policies set forth by Roberts Family Dental, PC.

Patient/ Guarantor's Signature (*Must be 18 years or Older*)

Date

Witness's Signature

Date