OFFICE POLICY & CONSENT

Please read the entire policy. If you have any questions regarding this policy, please do not hesitate to ask.

Dental Insurance Coverage: As a courtesy to you, we will file your insurance for you. In order to provide this service for you, we must have complete insurance information and confirmation of coverage. Insurance is a contract between you, the insured, and the insurer, not the doctor. Therefore, if any problems arise with the carrier, we will ask that you handle it with your insurance company.

Your insurance eligibility is not a guarantee of payment. We will file a claim on your behalf, your insurance company will process it and pay based on the usual and customary charge. This means that your insurance has a set fee for all dental work, we do not have access to these fees. Your insurance company should have provided you with these fees. Therefore, we estimate your percentage, and you agree to pay the estimated percentage the day of treatment, unless other payment arrangements have been made in advance. If you request it, we can send a pre-authorization to your insurance company. It takes 4-6 weeks and they will tell us exactly what they will pay per procedure. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid all the dental fees incurred. If your insurance does not cover all charges, the remaining balance if your responsibility.

If your account is not paid in full within three months of treatment it will become subject to a 38% collection fee and be turned over to a collection agency.

If you have a problem with any of the above policies, please speak to the receptionist BEFORE your visit with the doctor.

I understand and agree to honor my financial commitment to the office of Jasper Family Dentistry.

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

_____ _____

Signature of patient/guardian Date

Jasper Family Dentistry

706-692-2646 Fax 706-253-3202
391 North Main Street Jasper, GA 30143
jasperfamilydentistry@ellijay.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have read the Privacy Notice and understand my right contained in the notice.

By way of my signature, I provide **Griffeth Dental** with my authorization and consent to use and disclose my protected heath care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature Date

_____ _____
Authorized Facility Signature Date