

Gwinnett Dental Images
916 Lawrenceville Hwy., S., Suite 201
Lawrenceville, GA 30046
770-995-9255

FINANCIAL POLICY

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we need your assistance and understanding of our payment policy.

We Offer The Following Methods Of Payment Of Fees:

- Payment in full is due at time of service for those without insurance. A courtesy allowance of 5% is offered on fees over \$500.00.
- For patients with insurance, we will accept payment directly from the insurance company, **however, we required that the deductible and non-covered fees be paid at each visit.**
- We partner with CareCredit for a financing option. To apply go to www.carecredit.com. If approved, print off approval with your account number and bring to your appointment.

Important Information Regarding Your Insurance:

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy for you.
- Not all dental services are covered benefit in all contracts. **It is your responsibility to know your benefits.**
- You (not your insurance company) are responsible to us for all of our fees for services rendered to you.
- An *Estimate* will be given of the benefits that the insurance company is expected to pay. Remember that this is only an estimate and that the actual cost may vary.
- If your insurance company does not pay within 90 days of your date of service then you will become responsible to pay at that time.

We Request 24 Hours Notice For Changing Appointments:

We do not overbook patients, therefore, time has been set aside exclusively for your appointment. We request the 24 hour notice to fill times with patients who are waiting for sooner times. If we do not receive 24 hours notice, we will charge a \$50 broken appointment fee.

Collection Fees:

In the event payments are not received by the agreed upon dates, a 1-1/2% finance charge per month (18% APR) will be added to your account. If the account is sent to our collections attorney, *all collection fees and court costs will be your responsibility.* This will be reported on your credit report.

Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____