FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

Campbell Family and Cosmetic Dentistry is committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered. Our payment options are listed below:

1. We accept Cash, Electronic Checks through TeleCheck, MasterCard, Visa, American Express, & Discover.

2. We accept Care Credit, which is a third party credit source that offers interest free financing options. Please let us know in advance if you would like to start the approval process.

3. Any treatment plan that is pre-paid in full at the time of scheduling will result in a 10% discount.

In the event that a balance does result on an account, a $5 rebilling fee will be added to the account if the account is not paid in full by the due date of the first billing cycle.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R." is defined as usual, customary, and reasonable. This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all insurance plans. All insurance companies arbitrarily select certain services they will not cover.
4. You will be fully responsible for any balance not paid by insurance sixty days after your claim has been submitted. You will receive a bill from us showing the outstanding balance. We will be happy to provide any documentation to help assist you in collecting reimbursement from your insurance company directly.

We must emphasize that, as dental care providers, our relationship is with you, not your insurance company.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Patient Signature: _____ Date: _____

Campbell Family and Cosmetic Dentistry
48 Piedmont Drive Suite 302
Winder, GA 30680
770-868-8788

Consent for Services

I hereby authorize 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 my dental needs.
Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within sixty days of claim submission. I understand payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a $5.00 rebilling fee will be added to my account if the account is not paid in full by the due date of the first billing cycle.

_____	_____	_____
Signature of patient, parent, or guardian	Date	Relationship to patient

Acknowledgement of Receipt of Privacy Practices and HIPAA Statement

I have received a copy of the Notice of Privacy Practices and a copy of the HIPAA statement for the above named practice.

_____	_____	_____
Signature of patient, parent, or guardian	Date	Relationship to patient

Insurance Authorization

I authorize release of information to all my insurance carriers

I understand that I am responsible for any part of my bill not covered by my insurance

I understand that I will be billed for treatment not paid by my insurance sixty days after claim submission

I authorize payment directly to my doctor

I authorize my doctor to act as my agent in helping me obtain payment from my insurance

_____	_____	_____
Signature of patient, parent, or guardian	Date	Relationship to patient

*** We reserve on our schedule the necessary time for you to receive your recommended treatment. We ask that you please give us at least 24 hrs notice of any cancellation of an appointment. Thank you**.