proudsmiles
A Health-Centered Dental Practice
Brenda Paulen, D.M.D.
404-257-0091
5290 Roswell Road - Suite F - Atlanta, Georgia 30342

IMPORTANT OFFICE AND FINANCIAL POLICY

The following statements explain our Office Policies which we ask you to ***read and initial beside each policy, sign at the bottom of the page and return to us prior to your treatment.***

Dental Insurance:

_____ It is imperative to complete personal information and provide a copy of your current insurance card prior to your visit to ensure accurate billing. Once your dental benefits have been verified, we prepare AN ESTIMATE of your patient portion. Payment of your estimated portion is expected at the time services are rendered. Your insurance may not pay as estimated and you may have a balance due after insurance payment is received. Some insurance policies will reimburse patients directly and require you to pay your balance in full at the time of service.

_____ Our office can NEVER guarantee coverage for any services provided. Insurance companies will not guarantee benefits until a claim is received. It is important as a patient you educate yourself about your individual benefits. You must realize your insurance is a contract between you and the insurance company and/or your employer. While we maybe a provider of service, we are not party to the contract and may be considered an out-network provider. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Payment Options:

_____ For your convenience, we accept AMEX, VISA, MASTER CARD, DISCOVER, DEBIT CARDS, CARE CREDIT, CITI HEALTH, and personal checks. Individual financial arrangements can be made to assist you with your budget prior to initial treatment. Payment of your estimated patient portion, co-pays, deductibles, and prior balances are due at the time of service.

Appointments:

_____ We appreciate your promptness and consideration in not changing your scheduled time with the doctor and/or hygienist. Arriving more than 15 minutes after your appointed time is defined as late and may need to be rescheduled. However**, if you need to change an appointment a 2-business day notice is required**. This will allow us the opportunity to offer the appointment to another patient. Changes to an appointment without a 2-business day notice or a no-show will be subject to a cancellation fee based on an hourly rate appropriate for your visit and could range from $50.00-$500.00. Repeated changes, lateness, short-notice cancellations, or no-shows, are disruptive to the optimal delivery of your care. Cancellation fees cannot be billed to insurance and will be your responsibility.

_____ An appointment of 2hours or longer will require a 10% deposit of total treatment. Should you cancel without a 2-business day notice, a cancelation fee may be deducted from this deposit.

Past Due Accounts and Returned Checks:

_____ A 90-day overdue account will be turned over to a collection agency. Please be aware that a $50.00 processing fee as well as a fee of 40% of your balance will be added to your account.

_____ For checks returned to us as unpaid by your bank will be charged a $35.00 fee.

I have read and fully understand the statements above and the policies of Proud Smiles Dental.

Signature/Guardian: _____ ***Date:*** _____