APPOINTMENT AND PAYMENT POLICIES

Appointment Policy:

When an appointment is scheduled, please place the date and time on your calendar and be sure to arrive on time. If you arrive more than ten minutes late, your appointment may be rescheduled as there may not be adequate time to complete treatment for you. Non-surgical appointments such as exams and cleanings may be rescheduled **24 hours** prior to the appointment. This allows us time to offer your appointment time to other patients. There are no failed appointment fees. However, if you miss an appointment or give less than 24 hours notice, you must prepay for your next appointment in full. The prepayment is non-refundable if you miss the second appointment. A **20% deposit** is required for all surgical appointments or hygiene visits scheduled longer than one hour. Surgical appointments with the Doctors must be rescheduled **48 hours** prior to the appointment time or your deposit will be forfeited. Your signature below indicates that you understand our appointment policies and agree to abide by them.

Signature: _____ Date:_____

Payment Policy/Filing Insurance Claims: (Please <u>initial</u> where appropriate)

_____ **I do not have dental insurance** and understand that payment is due in full at the time of service and may be paid by check, cash, Visa, Mastercard, Discover, money order, or Care Credit. If my account is turned over to collections due to non-payment, a fee of 25% of the outstanding balance owed will be added to cover the cost of collections. **There is a $30.00 returned check fee.** I have read and understand the above payment policies.

Signature: _____ Date:_____

-OR-

_____ **I have dental Insurance** (please **<u>initial</u>** the following statements below after reading carefully):

_____ My insurance policy is a contract between my insurance company and myself. I acknowledge that the Doctors may not be preferred providers for my insurance plan and that **I am responsible for understanding my policy exclusions, deductibles, and required copayments.**

_____ Savannah Periodontics staff members do not represent my insurance company and I understand that their **estimates of my insurance coverage are only estimates and may not be accurate.** I understand that for treatments completed after my initial visit, my estimated co-payment will be due at the time of service and that Savannah Periodontics will file with my insurance company for the remaining balance. Payment in full of any remaining balance after my insurance pays will be expected within 14 days of the first billing.

_____ If my insurance company has not paid on a claim in 60 days, I understand and agree that I will be billed for the full balance and that a **$10.00 monthly service charge will be applied to any balances remaining after 60 days until the balance is paid in full.**

I hereby authorize Dr. Turner to release to my insurance company information acquired in the course of my dental care and authorize benefits to be paid directly to Savannah Periodontics. I understand I am responsible for any unpaid balance regardless of any estimate of benefits I may have been given. If my account is turned over to collections due to non-payment, a fee of 25% of the outstanding balance owed will be added to cover the cost of collections. **There is a $30.00 returned check fee.** I have read and understand the above payment policies.

Signature: _____ Date:_____

OTHER INFORMATION

Please indicate which pharmacy you prefer prescriptions to be called into:

Pharmacy: _____

Phone Number: _____

Communicating Personal Information:

Please list the names of people that we may openly discuss your treatment with (for example: husband, daughter, etc). You may choose to leave this section blank if you do not want us to disclose your health information to anyone:

Name	**Relationship to you**
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Messages About Your Appointments:

Please list any phone numbers where we may leave specific details of your appointment on your voicemail. If no phone numbers are provided, only appointment times and reminders will be left on voicemail:

1._____ ❑ Cell ❑ Home ❑ Work

2._____ ❑ Cell ❑ Home ❑ Work