PATIENT FINANCIAL AGREEMENT

WELCOME

We are committed to make caring for our patient's dental health our top priority. As always, we will strive to be courteous and kind to all and provide the absolute best dental care available in order to assure you and your family's well being. If any time, you have any questions or concerns, please do not hesitate to let us know.

APPOINTMENTS

Following your visit today, you may be appointed for additional dental care. We strongly encourage you to maintain all scheduled appointments but we do realize that unexpected emergencies occur. If you need to cancel/ reschedule your dental appointment, we ask that you **please provide our office with at least a 48 hour notice.** We often have a waiting list of patients who may desire an appointment on a certain day or have emergency appointments that may need see a dentist as soon as possible, so we need as much notice as possible for cancellations. All broken appointments (less than 48 hrs notice) will incur a charge to the patient's account.

DENTAL FEES AND INSURANCE ASSOCIATED WITH DENTAL CARE

Please understand that **payment is due for dental care provided at the time of your dental appointment.** If you would like us to assist you in obtaining reimbursement from your dental insurance, please understand that each and every insurance company is different as well as each employer and therefore, benefits offered by each insurance company and employer will vary. We will do our very best to assist you with understanding each benefit offered but we must ask you to accept this responsibility as well. **Patients are responsible for knowing the specific benefits and coverage provided by their insurance policy.** If you have any questions regarding dental benefits and coverage, please refer to your dental benefits booklet provided by your carrier and understand that… ***Insurance estimates quoted to your dental office are not a guarantee of dental benefits noted.***

If we are able to assist you and accept assignment of dental insurance, and for any reason, your insurance carrier elects not to reimburse our office for treatment provided, we ask that you understand that **you are responsible for 100% of ALL unpaid balances and payment will be due within 30 days of insurance claims processed.**

I, _____ *(print patient or responsible party name here)*, hereby understand the above statements and agree to meet the Financial Agreement guidelines as noted.

_____	_____	_____	_____
Patient Signature *(or Patient's Guardian)*	Date	DWC Staff Signature	Date

www.DentalWellnessCenterGA.com

DWC of JESUP
135 Peachtree Street
Jesup, GA 31545
912.427.2660 -Office
912.427.8158 -Fax
dwcj@live.com

DWC of RICHMOND HILL
10104 Ford Avenue; Suite G
Richmond Hill, GA 31324
912.445.5337 -Office
888.289.4301 -Fax
dwcrh@live.com

DWC of SAVANNAH
14045 Abercorn Street, Suite 2403
Savannah, GA 31419
912.920.5577- Office
912.226.3489 -Fax
dwcsav@live.com

DWC on PAULSEN
5209 Paulsen Street
Savannah, GA 31405
912.355.1512- Office
912.355.1218- Fax
dwcpaulsen@outlook.com

*RH -10/01/2017*bnT*

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name :_____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from Dental Wellness Center be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip:_____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____
Or to:
Recipient Name: _____
E-mail Address: _____ Phone: _____
Or to:
Recipient Name: _____
E-mail Address: _____ Phone: _____

I authorize the following PHI to be released from my dental record(s): Reports, Consultations, Test Results, Radiology film, Itemized Billing Records, Patient Medical History, Patient Treatment History and Patient Notes by Provider and dental team. I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.
Disclosure Format authorized by patient may be in the form of: Paper or Film Copies, US Mail, Fax, or E-mail.

By signing this authorization form, I understand that: I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Dental Wellness Center corporate office at the following address: 10104 Ford Avenue, Suite G; Richmond Hill, GA 31324. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date/event: Patient's request to inactivate from dental practice at Dental Wellness Center. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

www.DentalWellnessCenterGA.com

DWC of JESUP
135 Peachtree Street
Jesup, GA 31545
912.427.2660 -Office
912.427.8158 -Fax
dwcj@live.com

DWC of RICHMOND HILL
10104 Ford Avenue; Suite G
Richmond Hill, GA 31324
912.445.5337 -Office
888.289.4301 -Fax
dwcrh@live.com

DWC of SAVANNAH
14045 Abercorn Street, Suite 2403
Savannah, GA 31419
912.920.5577- Office
912.226.3489 -Fax
dwcsav@live.com

DWC on PAULSEN
5209 Paulsen Street
Savannah, GA 31405
912.355.1512- Office
912.355.1218- Fax
dwcpaulsen@outlook.com