Welcome to North Cumming Dentistry
We appreciate the trust you have placed in us.

Please be advised that you must turn off all cell phones and pagers once you are in the back office.

Insurance

Professional services are rendered and charges to you, not your insurance company. We will accept assignment for claims for primary insurance. Please understand that the contract is between you and the insurance company and payment for services is your responsibility. All deductibles and coinsurance amounts not covered by your insurance will be due at the time services are rendered.

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. **If at the end of 60 days, your insurance company has not paid, you are responsible for the entire balance**. Upon request we will supply you with a copy of the claim so you can resubmit it if necessary. We do not file secondary insurance.

In order to honor any insurance benefits, you must provide insurance identification of insurance cards, phone numbers & picture ID and we must be able to verify the current benefits available.

Please be advised that you may be billed for services that your insurance company will not cover due to exclusions or plan limitations. In most cases a pre-treatment estimate can be sent to your insurance company, therefore giving us an estimated portion due by you at time of service.

Office Fees

Payment is expected at the time service is rendered. We accept cash, check, visa and mastercard. If you present a check for insufficient funds or stop payment on an issued check, you will be charged a $45.00 processing fee and responsible for the entire balance in cash or money order. If any and all account balances are not paid in a timely manner, your account may be turned over to a collection agency and additional collection fees will be applied.

If you break an appointment with our office, we ask for a 24 hour notice of cancellation. If we do not receive a 24 hour notice, you will be charged a **$30.00 fee** for the scheduled appointment. This fee cannot be charged to your insurance company. If you repeatedly miss appointments you may be asked to pursue treatment elsewhere.

If you are more than 10 minutes late for your appointment you may be asked to reschedule.

I have read and understand the statements outlined above.

Signature _____ **Date** _____