Pettey Dental of Bartlett

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____

_____

_____

PETTEY DENTAL OF BARTLETT

FINANCIAL AGREEMENT

Thank you for selecting Pettey Dental of Bartlett as your dental provider. We are honored by your choice and we are committed to providing you with the highest quality healthcare. We ask that you provide us with the most correct and updated information about your insurance. You will be responsible for any changes incurred if the information provided is not correct or our office is not provided with your current or updated information.

Your dental benefits are based upon a contract made between you and your insurance company. If you have any questions regarding your dental benefits, **please contact your employer or dental insurance directly.** Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We estimate your portion based on the most up to date information we have, but it is only an estimate. If you would like to know your exact insurance benefit, we will be happy to file a "pretreatment authorization" with your insurance company prior to treatment. This does not GUARANTEE payment and will delay treatment, but gives you a more accurate figure you may require. This can also change due to deductible information or changes to your policy. **We bill your insurance as a courtesy. You are responsible for what insurance does not pay.** If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

We require payment in full for your portion at the time services are rendered. We accept Mastercard, Visa, Discover, American Express, Cash and Checks. If you are in need of an extended finance option, we also work with CareCredit, which offers 6 month or 12 month "deferred interest" options.

For cases that involve the laboratory, we require that you pay 1/2 of your portion at the first appointment, and the remainder of the balance on the day of completion. We reserve the right to reschedule your appointment if you are unable to pay your balance on the day of completion unless prior arrangements have been made.

A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 hour notice to avoid broken appointment fees.** After 2 rescheduled appointments, a deposit may be required to reserve your future appointments.
Patients may also incur and are responsible for the payment of additional charges. These other charges could include charges for returned checks and any cost associated with collection of patient balances.

We welcome you to our office and look forward to helping you get the healthy, beautiful smile you've always wanted.

I understand that I am financially responsible for all charges incurred at this office.

_____ _____

Printed Name Date Signature (parent if minor) Date