SOUTHERN FAMILY DENTAL GROUP

FINANCIAL POLICY/PRIVACY POLICY:

Southern Family Dental Group is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

1. **All patients must complete our "PATIENT REGISTRATION FORM" annually and/or before seeing the dental professional.**
2. **Full payment is due at the time of service.**
3. **We accept cash, checks, Visa, MasterCard, Discover, and Care Credit.**
4. **Southern Family Dental Group provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is ESTIMATED and due at the time of service.**
5. **Our practice is not a contracted provider with any insurance carriers; however, we file your insurance as a courtesy to you and help you get the most out of your insurance benefits based on your policy.**
6. **Insurance companies now require all claims to be filed within 90 days from the date of service, therefore, it is your responsibility that we have updated and correct information concerning your insurance.**

ADULT PATIENTS:

Adult patients are responsible for full payment at the time of service.

MINORS ACCOMPANIED BY AN ADULT:

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at the time of service.

UNACCOMPANIED MINORS:

The parents or guardians are responsible for full payment at the time of service. Non-emergency treatment will be denied unless charges have been pre-authorized by an approved credit plan, or to Visa, MasterCard, or Discover.

INSURANCE:

Southern Family Dental Group provides insurance company billing as a **COURTESY** to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. The amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. Also, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed the particular plan's

limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Southern Family Dental Group staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you are assigned those benefits to Southern Family Dental Group. However, if the insurance company pays you instead of Southern Family Dental Group, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You, as the patient, are always responsible for any charges that are not covered by your insurance.

DELIQUENT PAYMENTS:

It is our policy to charge finance fees of up to 18% if your bill is not paid in 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee that is charged to Southern Family Dental Group by our bank. If your account has to be turned over to a third party collection agency for non-payment, there will be a collection fee of 33% added to your bill. This is pursuant to GA Statutory Law "O.C.G.S.- 13-1-11"

PRIVACY POLICY:

I hereby acknowledge that a copy of Southern Family Dental Group Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature of Patient/Guardian/Representative **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ **Date of Birth**_____

Southern Family Dental Group is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Scheduled appointments ☐ Financial
☐ Spouse (provide name & phone #)	☐ Financial ☐ Medical ☐ Scheduled appointments
☐ Parent/Other (provide name & phone #)	☐ Financial ☐ Medical ☐ Scheduled appointments
☐ Email communication-provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach Notification
☐ For email communication I understand that if email is not sent in an encrypted manner, there's a risk it could be accessed inappropriately. I still elect to receive email communication.	

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Patient Guardian **Date**