OFFICE POLICIES

COMMERCIAL INSURANCE

As a courtesy to our patients, we will gladly submit your insurance claim to help you obtain the maximum benefits from your insurance.

- Dental insurance is based on the premium paid by you and/or your employer.
- Dental insurance helps in paying the cost of dental care.
- Dental Insurance policies may not cover services performed. It is your responsibility to contact your insurance company for complete details of co
- Patients are responsible to pay all charges insurance does not cover. In addition, you are also responsible for your co-payment.
- Your estimated portion not covered by insurance is due on the day of your dental services.
- Estimates given in our office are not guaranteed.

MEDICAID INSURANCE

As a courtesy to our patients, we will gladly submit your insurance claim to help you obtain the maximum benefits from your insurance.

- All services provided may not be covered under Medicaid.
- If your plan does not cover services it is your responsibility to pay. You must sign a non-disclosure form.

SECONDARY INSURANCE

- We do not accept commercial secondary insurance. However, we will provide you with the necessary paperwork for you to file.
- We will only submit to Medicaid.

PAYMENT OPTIONS

We realize that each person's financial situation is different therefore we provide several different payment options. For your convenience, we accept:

- Cash
- Personal Checks
- Major credit cards: Visa, Master Card, Amex, Discover
- Third Party Financing: Care Credit

REASON FOR RECEIVING A STATEMENT

You will receive a statement based on the following criteria:

- Difference between estimate of treatment and actual insurance payment.
- Any fees billed to your insurance company that are not paid within 30 days of the original dental treatment are billed to you for payment.
- If no payment is received, additional steps will be taken to collect the debt.

BROKEN APPOINTMENT POLICY

- Please consider your scheduled appointment carefully, as we set aside this time especially for your dental care.
- If you must break your appointment we require a **24-hour** cancellation notice, otherwise you will be charged $25.00. Your dental insurance will n this charge.
- If you fail to show or cancel three (3) appointments, all future appointments will be placed as a walk-in only status and we may be required to info insurance provider.

LATE ARRIVALS

It is important to arrive on time for your appointment. If you are going to be late please call our office. If you are more than 15 minutes late, we will need to reschedule the appointment.

BEHAVIOR (MINORS)

Treatment for minors includes efforts to guide their behavior by helping them understand the treatment by using praise, explanation and demonstration, using voice tones. If the minor becomes uncooperative during the dental procedures, dental treatment cannot be provided safely. We will stop treatment and refer t to our IV Sedation department.

FAMILY MEMBERS IN TREATMENT AREA

- Hygiene area.
  - The size of this area is limited; therefore family members are requested to stay in the waiting room area.
  - If patient must have another family member with them during hygiene treatment they will be placed in the Quiet Room area.
- Operatory area.
  - The size of this area is limited; therefore family members are requested to stay in the waiting room area.
  - If a family member requests to observe during treatment they can view through the observation window.

MINORS (18 & under)

A parent or legal guardian must remain in the office during the minor's treatment.

CELL PHONES

Cell phones must be turned off during treatment. Not allowed in clinical areas.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
(if patient is a minor under the age of 18)

Pleasure in Dentistry & Orthodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

Please read the following *statements*:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our *Joint Notice of Privacy Practices* before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. You are entitled to a copy of this form if you would like one... just ask.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised *Joint Notice of Privacy Practices*, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our *Joint Notice of Privacy Practices,* including any revision of our notice, at any time by requesting a copy at

A Smile 4U, LLC
HIPAA
366 N. Main Street, Suite 450
Alpharetta, GA 30009

Right to Revoke: You will have the right to revoke this consent ay any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the consent will not affect any action we took in reliance of this consent before you received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and A Smile 4U, LLC *Joint Notice of Privacy Practice*. I am giving my consent to A Smile 4U, LLC use and disclosure of my protected health care information to carry out treatment, payment activities, healthcare operations and other uses described in the A Smile 4U, LLC *Joint Notice of Privacy Practice* that was provided to me.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
(if patient is a minor under the age of 18)