Laser Dentistry
6111 Peachtree Dunwoody Rd
Bldg C Suite 202
Atlanta GA 30328 Tel: 770-671-1311

Dental Practice Policy

Dear Patient,
Please read, initial each paragraph and sign at the bottom

_______ Welcome to our dental practice. We appreciate the opportunity to assist with your dental needs and concern. Our goal is to provide you with the best dental care available in an efficient and professional manner. Together we can accomplish this goal. Like any business we have office policies that we must adhere to so that we can operate in a manner that will benefit our relationship. We will define those policies in the next couple paragraphs.

_______ We must have 24 hours notice should you be unable to come to your appointment. We will make every effort to confirm your appointment with you, however it is your responsibility to keep up with your appointment time. Failure to give us a 24 hours notice will result in a $40.00 broken appointment charge billed to your account. We have reserved this time for you and must know if you will be unable to keep it.

_______ All co-pays are due at the time treatment performed. As a courtesy, we will be happy to file your insurance. Please understand that treatment is not contingent or dependent on payment by your insurance company. Fees quote are an estimate base on information from your insurance carrier, not a guarantee of payment. Insurance claims that are not paid within 60 days become the sole responsibility of the patient. We will be happy to provide you with a copy of the claim we submitted to your insurance.

_______ We offer the convenience of credit card payment and also Care Credit to those who qualify. Please do not ask our office staff to work out payment plans for you.

_______ All products sold in our practice are non returnable

_______ Our office accepts fax eligibility, however faxed eligibility is not a guarantee of coverage. Should your insurance company deny the claim for any reason, we will bill our normal fees and all charges become your responsibility to pay.

_______ Account that have a balance as of the 1st of the month will incur a $9.00 administrative fee. In addition to the administrative fee, any account over 30 days will incur a 2% finance charge based on unpaid balance. These charges will accrue each month there is an outstanding balance. Account balances over 90 days past due will be transferred to a collection agency. In this situation, your account will be assessed a collection fee of 33 1/3% of the transferred balance. Our dental office will not release your medical treatment record without prior written approval from you.

_______ We try very hard to adhere to a schedule. If you are more than 30 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind, please be patient with us as it could be you with that emergency. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our dental practice and look forward to a long relationship with you and your family.

_______ I understand that dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results I acknowledge that no guarantee or assurance has been made by anyone of Laser Dentistry regarding the dental treatment that I requested and/or authorized. I understand that each dentist is an individual practitioner and is individually and solely responsible for the dental treatment rendered to me and any associated financial matters.

_______ I understand and agree to the above dental policies

Name: ____ Signature: _______________________________
Guardian signature if under 18

Date:______________________________