DUNSON
DENTAL • DESIGN

FINANCIAL DISCLOSURE STATMENT

1100 Peachtree St. N.E. Suite 680
Atlanta, Georgia 30309

Thank you for choosing Dunson Dental Design, (DDD). You can expect to receive the following bills for your visit:

Insurance: It is the responsibility of the patient to verify whether DDD is "in network" with their insurance plan. We will submit your insurance claim(s) to your dental insurance if the information is obtained and verified before your visit. If additional dental insurance is submitted to us after your visit, the patient or guarantor is responsible for any uncovered/denied balance. The patient or guarantor must pay for all dental services out-of-pocket, in full. To protect you against fraud, you must present your insurance card and government issued photo ID at your initial appointment.

Co-payments: DDD collects co-payments at the time of service. Additional payment may be required based on your insurance plan. In the event your account has a credit, a refund will be issued in a timely manner.

Refunds: All refunds will be processed within 3-5 days after the overpayment is discovered on the patient's account, or at the time the refund is requested. Patients who have insurance but made partial or full payment will not be refunded until after their claim has been processed and paid. Refunds for prepaid treatment will be processed within 5-7 business days.

Initial below:

_____ If we are unable to verify you have active coverage on the date of your appointment, you will be required to pay for the visit in full at the time of service. If your insurance information is later provided, we will issue you a refund after receiving payment from your insurance, as outlined above.

_____ In the vent you are unable to keep your appointment, please reschedule at least 48 hours in advance. First missed appointment will result in a $50 fee. Second missed appointment will result in a $100 fee. After three missed appointments in a twelve-month period, you may be subject to dismissal from our practice.

_____ **ALL SURGERY APPOINTMENTS THAT DO NOT CANCEL/RESCHEDULE 72 HOURS (3 FULL BUSINESS DAYS) PRIOR TO THE SCHEDULED APPOINTMENT WILL LOSE THEIR APPOINTMENT RESERVATION FEE.**

It is the patient's obligation to remember the appointment he/she/they scheduled with our practice. We understand that situations arise that may not permit you to give us a two-business day cancellation. However, exceptions to this policy will be determined on an individual basis according to the circumstances and our discretion.

_____ A $50 fee will be incurred for each returned check.

By signing below, I indicate my understanding of DDD's billing practices and that I may receive multiple bills related to my office visit as explained above. I authorize payment of my dental benefits to DDD and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any co-payment, co-insurance, deductible, and non-covered services amounts as outlined by my health/dental plan. This agreement applies to all visits that take place one year from the date this form is signed, and all bills resulting from those visits.

Patient/Guarantor Signature*: _____ **Date**: _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. *