PIEDMONT PERIODONTICS
& IMPLANT DENTISTRY

We are committed to providing you with the best possible care and 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 feel free to ask about fees, financial policy and /or your responsibility.

Confirming your appointment: Our by appointment only schedule books heavily in advance. Confirming whether or not you will be attending an appointment reserved for you based on your specific treatment is important. We will contact you two days before your scheduled appointment. Please confirm whether or not you will be attending the appointment. In the event you are late for an appointment, notifying us is appreciated so that we may determine if your appointment will need to be cancelled and/or rescheduled. We regret that we cannot continue to accommodate those who repeatedly fail or cancel appointments. Failed/missed appointments will incur a broken appointment fee or dismissal from the practice. Prepayment will be required to reschedule failed/missed appointments. Letting us know of your change in schedule allows us to accommodate patients with immediate needs and assures adequate time for your care. **Thank you for your respect of our time and other patient's time.**

Please provide at least two daytime phone numbers at which you may be reached and an email address:

Home Phone: _____ Cell: _____Work: _____

Email Address: _____

Treatment, billing & collections: Payment for your treatment is due on the day of scheduling. We happily provide a 5% professional courtesy for payment in full on day of scheduling by cash and/or personal check for patients who do not have dental insurance. If payment was not received in full on the day of scheduling, the remaining payment for your treatment is due on the day of service. Checks cannot be held. We accept VISA, MasterCard, Discover and American Express. I understand that as a condition of my treatment by this office, financial arrangements must be made in advance. Financing is otherwise only offered through Care Credit, which offers 6 and 12 months interest deferred (0% if paid in full within the promotional period) payment plans in the amount of $300.00 or more.

If you have dental insurance: Piedmont Periodontics & Implant Dentistry will file your insurance as a courtesy service since your insurance policy is a contract between you and your insurance company. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. By asking Piedmont Periodontics & Implant Dentistry to file insurance on your behalf, you are in agreement to paying the full amount regardless of what insurance agrees or disagrees to pay after treatment. Understanding the knowledge of all benefits is your responsibility as an insurance policy holder.

Consent for services: I hereby authorize doctor (or designated staff) to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Piedmont Periodontics & Implant Dentistry to make a thorough diagnosis of my/dependents dental needs. I also consent to the use of x-rays and/or intraoral photos taken of me for staff education, patient education and clinical studies by Piedmont Periodontics & Implant Dentistry. NO IDENTIFYING INFORMATION WILL BE USED.

I understand that the use of anesthetics and sedatives may be necessary and with their use embodies certain risks. I am aware that by my request, I am entitled to a complete recital of potential complications.

Patient rights/privacy practices: You have the right to look at or get copies of your health information, with limited exceptions. I grant my permission to you or your assignee to telephone me at home by cell phone or at my work to discuss matters related to this form and all aspects of my treatment and financial planning. I have read the above conditions of treatment and payment and agree to their content. You have the right to read the Notice of Privacy (HIPAA) which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Date: _____

Patient Signature: _____

Responsible Party Signature: _____ Relationship to Patient: _____