

**Dentistry at Windermere**  
2964 Buford Highway St. 200  
Cumming, Georgia 30041  
770-205-1212

### **Financial Policy**

**You could have chosen any number of dental practices in this area. Thank you for choosing Dentistry at Windermere!**

We appreciate the value of your time, just as you do! We strive for on time appointments and a personal, high tech dental experience at each and every appointment. You will have the doctors undivided attention, as they see only one patient at a time. Our treatment fees are within the range of other area practices that also provide cutting edge dentistry. Another perk, and as a courtesy to our patients, we will file your insurance electronically and send any required supporting documentation. Additionally, we will accept assignment of benefits (if you like), allowing you to pay just your **estimated** portion a time of service.

#### **ADMINISTRATIVE**

\_\_\_\_\_ I understand Dr. Lee and staff have reserved the allotted appointment time just for me. I will make every effort to keep my appointment. I will give as least one (2) working days notice for scheduling changes. A broken-appointment fee of \$50.00 may be assessed.

\_\_\_\_\_ I agree to be responsible for payment of all services rendered on my behalf or to my dependents.

\_\_\_\_\_ I understand that in the event that my account becomes 90 days past due and is turned over to collection that I will be responsible for all collection expenses incurred, such as fees, court cost and attorney fees.

#### **DENTAL INSURANCE**

We are happy to assist you in obtaining the maximum dental insurance benefits that your policy provides. Also, we will accept an assignment of benefits from your insurance carried for the **estimated** portion of your coverage. **Your estimated portion is due and payable at the time of service.** Also, we cannot be responsible for monitoring benefits, as that is up to the patient. If your insurance payment is not received within 60 days from the date of service, your balance will be transferred to your credit card account. At that time, we will provide you the necessary paperwork to receive payment directly.

**Remember, our professional Services are rendered to YOU, not your Insurance Company.**

\_\_\_\_\_ I authorize Dentistry at Windermere to submit my dental claims electronically and to assign benefits to be paid directly to them. I understand that the insurance company's unpaid portion is my responsibility, and I guarantee to pay any balance in full.

#### **CLINICAL CONSENT**

\_\_\_\_\_ I will update my (my dependents) medical history as required.

\_\_\_\_\_ I hereby authorize Dentistry at Windermere to take x-rays, study models, photographs and any other diagnostic aids as mutually agreed upon and deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

\_\_\_\_\_ Upon such diagnosis, I authorize Dentistry at Windermere to perform any mutually agreed upon treatment, and to employ such assistance as required to provide proper care.

\_\_\_\_\_ I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

\_\_\_\_\_ I have read and understand the medical and dental history provided.

**Print Patient Name:**

**Patient Signature:**

**(or Guardian if minor):**

**Date:**