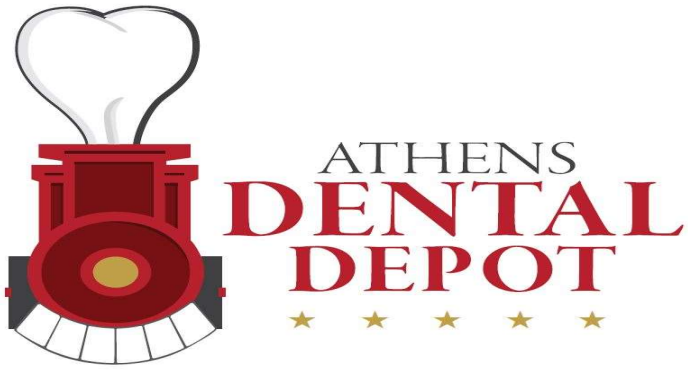

Financial Policy

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care, using only the highest quality materials and technology available in the market today. All charges you incur for any provided treatment are your responsibility, regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment.

Payment is due at the time of service. We accept Cash, Check, Visa, MasterCard, Discover and American Express. Debit cards displaying the Visa or MasterCard logo are also accepted. You may also use your flexible spending account through your employer, as long as they have provided you with a debit card. If you need to make payments over a period of time, we have interest free options available upon approved credit.

If you have dental insurance, we will be happy to file your dental insurance claim as a courtesy to you. However, your estimated portion is just that, an **ESTIMATE**. If there is any remaining balance after we receive payment from your insurance company or insurance payment is not received within 60 days that balance will be due within 15 days of notification. Failure to pay your account balance in a timely manner will result in finance charges, billing charges, and/or your account being turned over to a collection agency. At such time, additional processing fees may be added and this action will adversely affect your credit rating.

Signature: _____ Date: _____

Appointment Policy

We make every effort to value your time and we schedule your appointment time just for you.

We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care.

We will not charge for your first missed appointment. However, after two missed appointments in a 12 month span, you may be required to make a deposit when scheduling the next appointment. If you keep the appointment the deposit will be applied towards treatment. However, if you fail to keep the appointment a second time, the deposit will be forfeited.

We ask that you confirm your appointment a minimum of 48 hours prior to your visit. You may confirm via email, text message or by calling our office during business hours. Failure to show for your appointment may result in the loss of the time reserved for you and your treatment and a loss of your deposit.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Thank you for allowing us to share our appointment agreement with you. Please let us know if you have any questions

Appointment Agreement

- I acknowledge an appointment is a reservation.
- I agree to provide a minimum of 48 hours notice if I need to change my appointment for any reason.
- If I change 2 appointments without the required 48 hours notice in a 12 month span, I acknowledge I may be asked for a deposit at time of scheduling in order to be appointed.
- I understand that I must confirm my appointment 48 hours prior to my appointment or forfeit the appointment and any and all deposit.

Signature: _____ Date: _____

Insurance Authorization Signature on File

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record. **Please sign both authorizations**.

AUTHORIZATION TO RELEASE INFORMATION: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

AUTHORIZATION TO PAY BENEFITS TO TREATING DENTIST(S): I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Athens Dental Depot.

X _____ Date _____

Signed (patient, parent or legal guardian if minor)

I am aware that the insurance coverage fees presented to me by the dental office staff are only an estimate. All treatment not covered by insurance; I the guarantor will be responsible of the amount unpaid.

Signature _____ Date _____

Signed (patient, parent or legal guardian if minor)

Testimonial Release

Use of Name and Testimonial Release

I give Athens Dental Depot permission to use my name, comments, photos and intra-oral pictures in any marketing testimonial communication material prepared after my office visit.

Permission is granted to use all or any part of my testimonial, as indicated below, and to edit the testimonial as necessary, provided that such editing does not materially change the information or viewpoint I provided.

I understand that I have the opportunity to review my testimonial periodically and to make changes when needed.

Signature: _____ Date: _____