



Northwest Periodontics

*Stanley D. Halpern, D.D.S., P.C.
Laser Therapy and Dental Implants*

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Suite 102

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Office Policies

We are committed to providing you with the best possible care. We emphasize our team's relationship with you and your optimal dental health. We are pleased to discuss our professional fees with you at this time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- All patients must complete our "PATIENT INFORMATION FORM" before seeing the doctor.
- All applicable co-pays, personal balances, both current and prior are due at the time of service.
- WE ACCEPT CASH, CHECKS, DISCOVER, VISA/MASTERCARD and AMERICAN EXPRESS

Please circle your payment choice for today's visit.

REGARDING INSURANCE:

If you have insurance, we are happy to file your insurance claim as a courtesy. However, we do collect the full amount at the time of treatment. Any reimbursement will be sent directly to the patient from their insurance company. Late Payment Charges are added to unpaid accounts after 60 days from date of service. If your insurance company pays more than the balance due, we will send a refund check to you in a timely manner. **INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** Not every dental service is a "covered" benefit in all insurance policies. Policy limitations vary from contract to contract. Failure to provide updated insurance information may result in denials, which the patient will be held responsible.

MISSED APPOINTMENTS:

Unless cancelled at least 48 hours in advance, it is our policy to charge \$75.00 or 20% of the scheduled appointment fee, whichever is greater. This fee is not covered by insurance. After the first broken appointment, Northwest Periodontics reserves the right to require a deposit for any future appointments payable at the time of scheduling. This deposit is non-refundable if you cancel your appointment with less than 48 notice.

LATE ARRIVALS:

Patients who are 15 minutes late to their appointments **may** be asked to reschedule, or if the doctor's time allows you will be worked in around our other patients. The Atlanta Area is very congested with traffic and construction, so please allow extra travel time.

YOUR SIGNATURE IS REQUIRED FOR US TO:

- **PROCESS ALL INSURANCE CLAIMS**
- **TO ENSURE PAYMENT FOR SERVICES RENDERED (including all credit card payments)**
- **TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES**
- **TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT.**
- **TO RECEIVE INFORMATION FROM OTHER PROVIDERS AND INSURANCE COMPANYS TO FACILITATE YOUR TREATMENT**

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical surgical benefits, including major medical to which I am entitled, to Stanley D. Halpern, D.D.S., P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I further agree to pay all costs of collection, including costs of a collection agency, if the account is turned over to a collection agency.

Responsible Party's Signature: _____

Today's Date: _____

Please print the following information

Patients Name: _____

Responsible Party's Name if other than Patient: _____