GRACE DENTAL
FAMILY & COSMETIC DENTISTRY

Acknowledgement of Office Policies

___ I hereby authorize the release of any information necessary to process an insurance claim and request direct payment to Grace Dental.

___I understand that fees are to be paid at the time the services are performed.

___I understand that it is my responsibility to understand my dental insurance. Grace Dental is only given an estimate of my coverage through my insurance company. I am responsible for any balance my insurance does not pay.

___I understand that I am responsible for the payment of $40 per hour for appointments cancelled with less than 24 hours notice prior to my next visit except in case of emergencies or serious illness. I understand that I will not be given any other dental appointments until this balance is paid. I further understand that my insurance company will not pay for this charge.

___I understand that if I miss three appointments without 24 hours notice of cancellation, I may be discharged.

___I understand that my treatment plan will be created based on my dental needs, not what my insurance covers.

___I understand that if I require a procedure that requires two or more hours I will be asked to put a deposit of $100.00 that will go towards my dental procedure.

___I understand that based on Tennessee state law children under the age of 18 must be accompanied by a parent or legal guardian to All dental appointments.

___I understand that children should not be brought with an adult when the adult has the scheduled appointment. It is not in the best interest of the child, the adult patient, nor our staff.

___I understand that if I am over 18 years old any issues regarding my treatment and or my account cannot be discussed with family members or friends unless I specify in writing. All other communications will be in accordance with the HIPPAA guidelines. (Please ask the front desk for more information if you wish to add your spouse or family member.)

___I understand that under normal circumstances dental work is guaranteed for one year providing that I take appropriate care of my mouth, received regular six month check ups and have regular cleanings.

___I understand that my dental record information belongs to me but my dental records, radiographs, photos, and study models are the property of Grace Dental. If I request dental records, I am aware there will be a standard fee of $20 for these records.

___I understand that if a check written for my account to Grace Dental is returned for insufficient funds, a returned check fee of $60 will be added to the original balance of my check and I am responsible for paying this amount prior to any further dental appointments.

___I understand that should my account balance not be paid in a timely manner, it will be turned over to our collection agency. I will be responsible for any billing, finance, legal or collection fees, which may occur.

___I have read and understand the entire Grace Dental office policy and am in receipt of a copy of this policy for my records.

Witness_____ Printed Name_____

Signature_____ Date of signature_____