

Diamond Dental Group, P.C.
4879 Lavista Road, Suite 300
Tucker, GA 30084
Phone: (770) 938-5828

A Statement of Financial Guidelines for Our Patients.

First, please allow us to welcome you to our office. We hope to make your visit as pleasant as possible. Unfortunately aside from the emotional and physical impact of any dental treatment, there is all too often a degree of **financial impact** as well. We would like to ease your potential financial burden as much as possible. Your review of our financial guidelines at this time will help greatly to avoid future misunderstandings and make everyone's job that much easier.

1. Our relationship and our contract with you is that of **Dentist – Patient**. We do not provide dental services to insurance companies and have no responsibility to assure that the insurance company is pleased with your dental care.
2. Any contract that exists between you and your insurance company for dental care reimbursements does not obligate us to comply with the provisions of your policy. **We will assist you in filing your claims.** If you are unsure of any of the specific requirements of your insurance company please ask them. **Benefits can vary depending on your individual plan.**
3. We do not file under any circumstances for medical coverage with your insurance company.
4. **Payment is expected at time of service for all procedures not covered by your insurance.** We accept, cash, check or all major credit cards.
5. Often insurance companies will use the term “usual and customary” or similar such language when denying charges for dental care. The implication is that the doctor charges too much for a given procedure or visit. **Universal “usual and customary” fee schedules do not exist.** The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of the policy. Our fee schedule is the same for everyone! The only time there is a variation in charges is when there exists a contract between us and an insurance company to provide care at a discount in exchange for qualifying as a “participating provider – dentist”.
6. In the event of default patient/guarantor will be responsible for **all** collection costs, including attorney, court fees.
7. We require **2 business days cancellation notice.** Should you not give the necessary notice, you will be responsible for the **\$50.00** charge.

We are here to serve you for your dental care needs. If we have done well, please tell your family and friends. If not tell us!

I have read and understood the above. I have kindly been given a copy of this document for my records.

Credit Card #: _____ Expiration Date: _____
(Apply to my credit card only if my account is older than 45 days)

Signed: _____ Date: _____