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## OUR POLICIES

### DEAR PATIENT/RESPONSIBLE PARTY/GUARANTOR;

Roberts Family Dental's primary concern and commitment is to provide quality dental care for our patients. Please read this financial policy in its entirety, complete the form as required and return it to the receptionist. Your signature is required on this form prior to any treatment. We are committed to providing quality care to each and every patient. In order to accommodate the needs and requests of as many patients as possible, we will explain your financial obligations to the best of our ability, prior to treatment. It is a policy within this practice, that in the event payments are not received as agreed upon, a 1-1/2% late charge (18% APR) may be added to Your account.

**Thank you...** for taking the time to read and complete this form. It will enable our office to be more effective in meeting your needs. If you have any questions at anytime, please ask us, we will be happy to help. **Remember that you, the Patient/Responsible Party/Guarantor, are ultimately responsible for payment of your account.**

...The Doctors and Staff of Roberts Family Dental, P.C.

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- 1) **INFORMED CONSENT FOR TREATMENT:** As the **Guarantor/Insured Party** (*herein referred to as I/us/my/we*) of this account, and for anyone enrolled under or added to this account, I hereby, give consent for the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of our dental needs. Upon such diagnosis, I authorize doctor to perform the recommended treatment agreed upon by us and to employ such assistance as required to provide proper care. We agree to the use of anesthetics, sedatives and other medication as necessary. We fully understand that using anesthetic agents embodies certain risk. We understand that we can request a complete recital, prior to the start of the anesthesia, of any possible complications related to our treatment. I confirm that the information we provided today is complete to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the doctor of any changes in my medical/dental/financial/personal information.
- 2) **OUR APPOINTMENT POLICY:** Our appointment schedule is designed to respect your time and convenience as well as efficiently utilize our facility. Sometimes there are unavoidable delays. If you have been waiting for more than 30 minutes and one of our staff members has not spoken to you concerning your appointment, please return to the front desk and ask for assistance.

A broken appointment is a loss to everyone. If you need to change or cancel your appointment, we would greatly appreciate at least a 24-hour notification, to afford us time to possibly give that reservation to another patient. Your cooperation will allow us to better serve our patients. We provide a 24 hour answering service, so that you may leave a message for the office if you are unable to reach us during normal business hours concerning your appointment.

**Please remember that there is a maximum \$50.00 broken appointment fee, which will be applied to your account, should you not provide us with the required 24-hour notification.**

- 3) **GUARANTEED INTENT TO PAY:** As the Guarantor/Insured Party (*herein referred to as I/us/my*) of this account, and for anyone enrolled under or added to this account, I hereby, guarantee payment to the office of Roberts Family Dental, or a representative of, Roberts Family Dental, for services rendered by the doctor and/or his agents; to us. I understand the doctor is acting in good faith by agreeing to perform said services prior to payment and this acts as my guarantee to pay the doctor in full for all services rendered. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (*18% APR*) may be added to my account.

- 4) **OUR PAYMENT POLICY:** Payment for services rendered is due at the time of service, unless prior arrangements have been made. We accept MasterCard, Visa, Discover Card, American Express, Cash, Checks and ATM debit cards. A current Georgia Driver's license or picture id is required.
- **Please make checks payable to: Roberts Family Dental**
  - **We do not accept out of state personal checks or third party personal checks.**
  - **There is a \$50.00 charge on all returned checks.**
- 5) **OUR FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT:** In order to comply with the "Truth in Lending Act" and the requirements of Regulation Z, we are required by law to retain a signed copy of any payment schedule in our file, even though no interest or carrying charge is included in the payment amounts. The payment schedule used by Roberts Family Dental, PC is referred to as a Financial Agreement (*herein referred to as an F/A*). If treatment is interrupted or discontinued, either party may initiate renegotiation of this agreement. Responsible Party also has the option of paying the balance off before the date stated in the F/A. There will be a late fee of \$50.00 per month for any payment that is more than 30 days late.
- 6) **AUTHORIZATION TO RELEASE PERSONAL, MEDICAL, DENTAL OR FINANCIAL INFORMATION:** As the **Guarantor/Insured Party** (*herein referred to as I/our/us/my*) of this account, and for anyone enrolled under or added to this account, I hereby authorize Roberts Family Dental, P.C. or a professional entity affiliated with them, to give the health plan/insurer; the collection/legal agency and the employer or any of their designees, any and all records or information pertaining to Our personal, medical, dental or financial history. For services rendered to us, for any administrative purposes, including evaluation of an application or a claim, for any collection process in the case of default of payment for services rendered and/or for any analytical or research purposes. I also authorize on behalf of us, the use of a social security number for purpose of identification. A photocopy of this authorization will be as valid as the original.

**As the Guarantor of this account, I have read and understand the financial policies stated above and agree to accept financial responsibility as described, for all services rendered, and for anyone enrolled under or added to my account. It has been explained to me, and I understand and I agree, that I am responsible for the entire Professional Fee, including any portion of the Estimated Insurance Benefits amount (if any) that is not paid by insurance. I also understand that there will be additional charges for broken or and for missed appointments.**

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Guarantor's Signature (MUST be 18 years or older)\_

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Date (Month-Date-Year)

*Last Rev Date: 2008-03-23*

