GEORGIA SMILES
780 SCENIC HWY
LAWRENCEVILLE, GA 30046
678-215-1300

Financial Policies

Patient Name:

Patient DOB:

Responsible Party Name :_____
(The adult accompanying the patient is considered the responsible party for the service billed)

Dr. Ron Chemmalakuzhy is committed to meeting your dental care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this we ask that you adhere to the following guidelines. Please initial each line.

_____ It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. If you do not have proof of a current insurance at your visit, you will be considered a self pay patient for that visit and payment will be due in full that day.

_____ It is your responsibility to contact your insurance carrier to confirm that our provider participates with your plan. **It is also your responsibility to understand your insurance benefits and requirements.**

_____ It is your responsibility to provide us with any legal documentation or divorce decree dictating a specific parent/guardian responsible for dental coverage.

_____ Co-payments are due at the time of service, before your appointment, as per our contract with your insurance carrier. We accept the following forms of payment: checks,cash,credit cards and money order. Any check dishonored by your bank may result in a $35 return check charge being added to your account and your account going to a cash only payment basis.

_____ **No Shows and Cancellations:**
If you fail to cancel 48 hrs prior to your scheduled appointment time, you may be charged a "No Show" fee of $75 for the missed appointment. Please remember that we have reserved appointment times especially for you.

_____ All dental records requests must be in writing and received in our office 7-10 days prior to the date needed. Records will only be mailed, not faxed and all dental records requests will have a fee based on the number of pages.

Responsible Party Signature: _____ **Date: _____**

Printed Name of Responsible Party: _____