TEBO DENTAL GROUP

TEBO DENTISTRY FOR KIDS LILBURN
609 BEAVER RUIN ROAD NW SUITE A
LILBURN, GEORGIA 30047
PHONE: 770-925-3300

TEBO FAMILY DENTISTRY LILBURN
609 BEAVER RUIN ROAD NW SUITE B
LILBURN, GEORGIA 30047
PHONE: 770-925-3300

TEBO DENTISTRY FOR KIDS GAINESVILLE
3535 THOMPSON BRIDGE ROAD
GAINESVILLE, GEORGIA 30506
PHONE: 770-925-3300

TEBO DENTISTRY FOR KIDS DACULA
1152 AUBURN ROAD SUITE 101
DACULA, GEORGIA 30019
PHONE: 770-925-3300

Appointment and Payment Agreement

The undersigned agrees to pay all charges related to the treatment of the patient at the offices of Tebo Dental Group and agrees to the terms and conditions stated below. If two or more persons are responsible for charges, then all responsible persons shall be jointly and severally liable for the patient's charges.

Missed or canceled appointments

If an appointment needs to be canceled, please notify us at least 24 hours or 1 business day in advance of the appointment. Appointments scheduled on Mondays must be canceled prior to the time of the scheduled appointment on the preceding Friday or the appointment will be considered a Broken Appointment. Our office hours are Monday through Friday from 8:00 am to 5:00 pm. While we do not charge a Missed Appointment Fee for canceled or missed appointments, we do stand firmly behind our missed appointment policies in an effort to offer the best possible experience for our patients who make it on time for their appointments.

Payment is due at the time of treatment

Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements. We offer 3rd party financing in the event the patient cannot pay for the treatment in full. Ask staff member for details.

Insurance claims

If we file an insurance claim for the patient, you will need to pay us at the time of treatment the expected insurance deductible and any amount that we expect insurance will not cover. We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charges, whether or not the insurance company provides any coverage. If your insurance company does not pay on the claim within 30 days from the date of service, the balance is the sole responsibility of the patient.

Returned checks

We charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments

Please pay all charges on time. We charge interest at the rate of 1.5% per month for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

Collection costs

We will charge the patient's account for our collection costs if we refer the account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For accounts referred to a collection agency, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

Consent to Disclosures concerning Treatment or Charges

If we try to contact you concerning the patient's treatment or charges and reach instead someone we believe to be directly involved in the patient's care, such as your spouse, another family member, other relative or close personal friend, you consent to our disclosure to that person of any information our office finds appropriate concerning treatment or charges for the patient. If the patient is covered by insurance, you also consent to the disclosure of information related to the patient's treatment or charges to the policyholder or person primarily insured under the policy.

X _____ Date signed: _____

Signature of person responsible for charges

Name of signer: _____ Name of patient: _____

Relationship of signer to patient (if self, so state): _____

*If the signer is not the patient and is not the patient's HIPAA personal representative (i.e. a custodial parent, guardian or other person authorized to act on behalf of the patient in making health care decisions), then the patient (if an adult) or the patient's personal representative should sign a separate Appointment and Payment Agreement or an Authorization to Release Information to Third Party (contained in the office's Privacy Policies), to authorize the disclosures described above concerning treatment or charges.