Atlantic DENTAL ASSOCIATES

WRITTEN FINANCIAL POLICY

Terms of Payment

The following is a guide to the terms of payment we accept. We are committed to working with you to match a payment plan to your needs; therefore we offer different options to our patients, which allows for payment to be convenient and flexible. We are available to answer any questions you may have.

Dental Insurance

We will gladly assist you with your insurance plan. To help us assist you in determining your maximum benefit, ***please bring your insurance card to your first visit***. Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made.

Please be aware that some and perhaps all of the services provided may be non-covered services and not considered necessary under your insurance guidelines. If you're insurance company has not paid within 30 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

Payment Options

- We accept **Visa, MasterCard, American Express, Discover or personal check.**
- A convenient interest free plan through an outside financial institution.
- A pre-authorized monthly payment plan on your credit card.

Appointments

In order to allow the best possible care for our patients we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a 24-hour notice is expected.

PATIENT AGREEMENT

- I understand that my insurance policy is a contract between myself and the insurance company; therefore I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Atlantic Dental Associates or Dr. Frederick Allen Williams.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

I have read the above information. I understand and agree to this Financial Policy.

X____ Date:______________

Signature of Patient/Responsible Party

Frederick A. Williams, DMD, PA

343 Whiteville Road • P.O. Box 607 • Shallotte, North Carolina 28459 • TEL 910-754-6718 • FAX 910-754-4446

www. AtlanticDentalNC.com • contactus@atlanticdentalnc.com