Welcome!

WELCOME TO OUR OFFICE. THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM. FOR YOUR INFORMATION, OUR OFFICE AND FINANCIAL POLICIES ARE NOTED BELOW. IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESITATE TO ASK.

- PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. THAT INCLUDES DEDUCTIBLES AND PERCENTAGES NOT PAID BY INSURANCE. WE ACCEPT CASH, PERSONAL CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT.

- IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE INFORMATION ON THE PATIENT INFORMATION FORM. PLEASE REMEMBER THAT YOUR INSURANCE PLAN IS A CONTRACT BETWEEN YOUR EMPLOYER AND THE INSURANCE COMPANY. MOST INSURANCE COMPANIES WILL NOT COVER 100% OF DENTAL EXPENSES. ALL PATIENTS ARE FINANCIALLY RESPONSIBLE FOR THEIR ACCOUNTS. IF INSURANCE CLAIMS ARE NOT PAID IN A TIMELY MANNER, THE BALANCE OF THE CLAIM BECOMES YOUR RESPONSIBILITY. AS A COURTESY TO OUR PATIENTS WE ARE HAPPY TO FILE YOUR CLAIMS WITH MOST INSURANCE CARRIERS. WE ARE NOT IN-NETWORK OR A PREFERRED PROVIDER WITH ALL INSURANCE COMPANIES. OUR OFFICE WILL ALWAYS WORK WITH YOU TO HELP WITH YOUR INSURANCE BUT PATIENTS ARE RESPONSIBLE FOR KNOWING HOW THEIR DENTAL BENEFITS WORKS.

- ON RECONSTRUCTION CASES (I.E. CROWNS, BRIDGES, PARTIALS AND DENTURES), 50% OF THE FEE IS DUE AT THE FIRST APPOINTMENT AND THE BALANCE IS DUE AT THE TIME OF DELIVERY.

- ON BALANCES REMAINING AFTER 30 DAYS THERE WILL BE A 1.5% SERVICE CHARGE. ANY BALANCE OUTSTANDING OVER 60 DAYS WITH NO EFFORT IN PAYMENT WILL BE SUBJECT TO COLLECTION PROCEEDINGS. ALL APPOINTMENTS WILL BE REMOVED FROM OUR SCHEDULE UNTIL THE BALANCE IS PAID IN FULL. ANY COSTS INCURRED IN THE COLLECTION PROCESS WILL BE THE RESPONSIBILITY OF THE GUARANTOR OF THE ACCOUNT.

- THE PARENT WHO BRINGS A MINOR CHILD TO THE APPOINTMENT IS RESPONSIBLE FOR THE FEE THAT DAY.

- MINORS OR YOUNG ADULTS ARRIVING FOR APPOINTMENTS WITHOUT A PARENT/RESPONSIBLE PARTY MUST HAVE A PAYMENT METHOD PREPARED BEFORE THE TIME SERVICES ARE RENDERED. (CALL IN PAYMENT/ LEAVE CREDIT OR DEBIT CARD ON FILE, ETC.) MINORS/ YOUNG ADULTS SENT WITHOUT A METHOD OF PAYMENT WILL BE ASKED TO RESCHEDULE THEIR APPOINTMENTS.

- MINORS MUST HAVE AN UPDATED MEDICAL HISTORY ON FILE TO BE SEEN. PLEASE FEEL FREE TO CALL AND ASK OUR OFFICE IF ONE IS NEEDED. PATIENTS ARE ABLE TO COMPLETE A MEDICAL HISTORY FORM OFF OF OUR WEBSITE WWW.DACULAFAMILYDENTISTRY.COM.

- TO BE SEEN, PATIENTS MUST SIGN THIS FORM, THE CANCELLATION POLICY FORM AND, AN UP TO DATE HEALTH HISTORY.

BY SIGNING THIS FORM YOU ACKNOWLEDGE AND ACCEPT OUR OFFICE POLICIES.

_____ _____

GUARANTOR SIGNATURE DATE

Office Cancellation Policy

Please read thoroughly.

- APPOINTMENT TIMES ARE RESERVED EXCLUSIVELY FOR YOU.
- WE CALL AND SEND REMINDERS AS A COURTESY TO OUR PATIENTS. IF FOR SOME REASON YOU ARE UNABLE TO CONFIRM AT THAT TIME, WE DO ASK YOU TO PLEASE RETURN THE CALL. (APPOINTMENTS CAN BE CONFIRMED WITH OUR VOICEMAIL SERVICE.)
- APPOINTMENTS WITHOUT CONFIRMATION ARE NOT GUARANTEED AND MAY BE REMOVED FROM THE SCHEDULE AS WELL AS POSSIBLY INCURRING A CANCELLATION FEE.
- IF IT IS NECESSARY TO CANCEL OR CHANGE AN APPOINTMENT, WE ASK FOR AT LEAST 24 HOURS NOTICE WITH GOOD CAUSE.
- PATIENTS OR FAMILIES WHO HAVE EXCESSIVE CANCELLATIONS OR RESCHEDULED APPOINTMENTS WILL BE ASKED TO MAKE DEPOSITS TO SCHEDULE FUTURE APPOINTMENTS.
- ANY CANCELLATION FEES INCURRED WILL BE POSTED TO THE ACCOUNT OF THE RESPONSIBLE PARTY. ANY FUTURE OR EXISTING APPOINTMENTS HELD BY THE RESPONSIBLE PARTY OR LINKED FAMILY MEMBERS MAY BE REMOVED FROM THE SCHEDULE UNLESS A DEPOSIT IS MADE.

OUR OFFICE STRIVES TO COMMUNICATE WITH OUR PATIENTS. WE VALUE YOUR TIME AND WE THANK YOU FOR VALUING OURS.

BY SIGNING THIS FORM YOU ACKNOWLEDGE AND ACCEPT OUR OFFICE POLICIES.

_____ _____

PATIENT SIGNATURE DATE

Dacula Family Dentistry

I authorize Carey L. Norton, DMD, PC/ Dacula Family Dentistry to release dental information including appointment information, treatment information, test results, insurance information, and any account balance information to any facility I am referred as well as the following individuals:

_____

_____

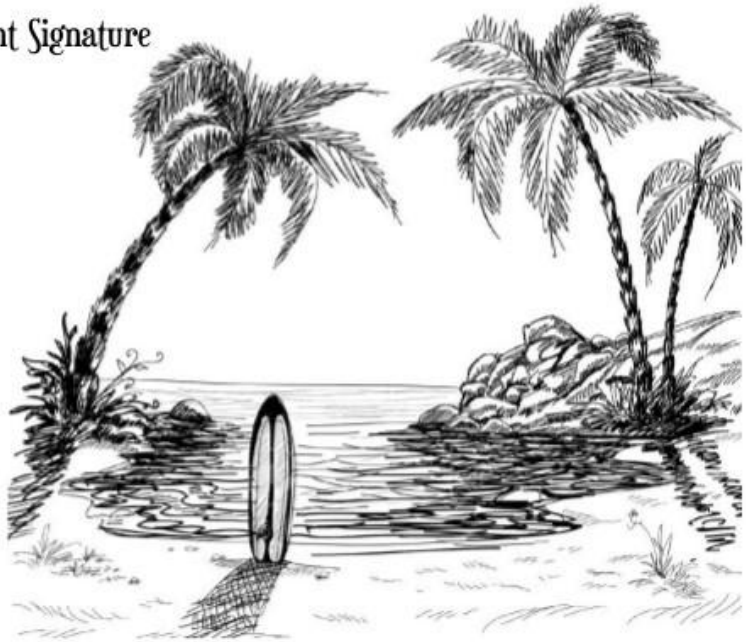
_____

_____

I understand that no information will be released to any individual unless they are listed above. This authorization will remain in effect unless I notify the office otherwise.

_____

Patient Signature Date



DACULA FAMILY DENTISTRY
100 DACULA RD, DACULA, GA 30019
(770) 995-1600

Dacula Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may Refuse to Sign This Acknowledgement*

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify):

_____

_____

_____

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