Financial Policy

Patient Name (Last, First, Middle) _____

In our continued commitment to provide the highest quality dental care to all of our patients while offering affordable services, we are pleased to offer the following options: We accept: Cash, Check, Care Credit, Visa, Discover, MasterCard, American Express.

We are committed to supporting you in understanding your dental health so that you will be able to make the best, most informed decisions.

We will, as a courtesy, process your insurance on your behalf at the time of your visit. Please understand that this is an estimation and having dental insurance does not relieve you of your financial responsibility.

I certify that I am covered by insurance and I assign directly to BRUCE A HESTER D.M.D. P.C. all insurance benefits. I authorized the use of my signature on all insurance submissions.

I agree that I am fully responsible for the total payment for all procedures- this includes, but is not limited to, any treatment that is not a covered benefit of any dental insurance benefits I may have. I acknowledge **that all services are to be paid in full at the time services are rendered**. If any insurance company denies payment on a claim for any reason, I understand that it is my responsibility to pay the balance of that claim within 10 days of the denial. Insurance will be filed for primary coverage only. If you have secondary insurance, it is your responsibility to ask for appropriate forms so that you may file the claim. Patients without dental insurance are expected to pay the balance in full when services are rendered.

We reserve the right to take legal actions on any delinquent account to include but not limited to turning the account over to a collection agency, reporting the delinquency to the credit bureau and if necessary, filing suit. A **$25 fee** will be applied to all returned checks.

We are here to assist you in any way possible. Please make your questions and concerns known to one of our team members. Our goal is to ensure that you have an outstanding experience.

If the patient is a minor (under the age of 18), please provide information for the parent or legal guardian:

Parent/ Legal Guardian Name:_____
Relationship to patient: _____

I consent, that I am the patient, and there are no court orders now in effect that prohibit me from signing this consent. I do hereby and request and authorize the dental staff to perform necessary dental services.

Patient/Parent/ Legal Guardian Signature: _____ Date: _____

Hester Dental
2980 Lewis Street, Kennesaw, GA 30144 770-422-1554

Please complete back of form

Consent For Use and Disclosure of Medical Health

Section A: Patient Giving Consent

Patient Name (Last, First, Middle) _____

Section B: To The Patient- Please read the following statement carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected healthcare information to carry out treatment, payment activities, and healthcare operations. You may obtain a copy of our Notice of Privacy Practices by contacting our office.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice may accompany this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices at any time. If any changes are made, we will issue a revised notice, which will contain those changes which may apply to any of your protected health information that we maintain.

Right to revoke: You will have the right to revoke this consent at all times by giving us written notice. Please understand that revocation will not affect any action we took in reliance on this consent and that we may decline to treat, or continue treating you based on your revocation.

If the patient is a minor (under the age of 18), please provide information for the parent or legal guardian:

Parent/ Legal Guardian Name:_____

Relationship to patient: _____

Patient/Parent/ Legal Guardian Signature: _____ Date: _____

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