Flat Creek Family Dentistry, P.C.
500 Stevens Entry
Peachtree City, GA 30269
770-487-5327

Financial Agreement and Dental Insurance Coverage

We are committed to provide you with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless prior payment arrangements have been approved in advance by our staff. We accept cash, personal checks, MasterCard, Visa, Discover, and American Express. We will be happy to file your insurance claim for you. If insurance benefits have been assigned to our practice, and have not been paid within 60 days of the date of service, you will be responsible for the balance.

Balances greater than 90 days may be subject to additional collection fees and interest charges of 1% per month. Charges may also be incurred for broken appointments cancelled without 48 hours advanced notice.

Regarding insurance contracts:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies which pay a percentage (such as 50% or 80%) of "U.C.R". "U.C.R" is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most insurance companies. This statement does not apply to companies which reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies may not cover all necessary procedures.

I hereby authorize Flat Creek Family Dentistry, P.C. to release any and all medical and dental information pertinent to my treatment to my insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payments directly to Flat Creek Family Dentistry, P.C. of the dental insurance benefits otherwise payable to me, for services rendered to me by the doctors or their staff. I have been informed that their office will report my diagnosis, treatment and fees to my carrier(s) in accord with standard conforming to the current procedures established by the American Dental Association, and that is the sole power and responsibility of my carrier(s) to determine the actual dollar amount of benefits for all services rendered. ***I understand that I am ultimately responsible to the total cost of my treatment*** provided by Flat Creek Family Dentistry, P.C. or their staff. This authorization remains valid and effective from the date of signing, until revoked in writing. I acknowledge that I have read and understand the above statement.

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Signature of Patient or Patient's Legal Guardian

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Date of Signature