James D. Allen, DDS
George H. Clayton, DDS
1177 Old Hickory Blvd. Suite 102
Brentwood, TN 37027

# Payment/Insurance Policy

## To Our Valued Patients:

**In order to serve you better we request that you read the following information carefully and sign your name at the bottom acknowledging that you understand our payment and insurance policies.**

**As a courtesy, we will file your primary and secondary dental insurance, if applicable. We are providers with Delta Dental insurance; all other PPO insurance policies can be filed for out of network benefit. We are not able to file to any HMO or DHMO polices. In order to assist in this process, a dental insurance card MUST BE PROVIDED to our office. If you have not been given a card, you are responsible for providing us with: the name of the insurance company, the billing address, a phone number, a group number, and the name of your employer. Dental insurance is not intended to pay your dental bill in its entirety. It is strictly an aid to help with dental expenses. The patient's *estimated* portion is due the day of service. Sometimes your dental treatment may not be a covered expense with your dental insurance plan. You have the right to request the proposed treatment regardless if it is not a covered expense under your insurance plan. This is called "Optional Service." However, you will be responsible for the difference that the insurance will not cover at the time of service. This applies to all dental insurance policies including Delta Dental. If we have not heard back from the insurance within 60 days after the claim has been filed, the balance will then become the patient's responsibility.**

**Our office has a $100 consultation fee that is non waivable.**

**In the event the balance of this account or any portion of the account balance is turned over for collection, I, the undersigned, agree I will be responsible for collection cost and/or legal costs including attorney fees. I authorize this facility and/or it's agent to verify my employment at any time. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance. I further understand that a service charge will be added to any overdue balance.**

**We have a 24-hour cancellation policy. Appointments missed without a 24-hour notice will be subject to a $25 charge.**

**At the request of the patient or another doctor, we will be happy to forward your dental records. However, there is a $20 duplication fee for all dental records including x-rays.**

**We accept the following forms of payment:**

| | | |
|---|---|---|
| **Cash** | **Check** | **American Express** |
| **Visa** | **MasterCard** | |
| **Discover** | ***Care Credit*** | |

**We do not make monthly payment arrangements. However, we offer a program called "Care Credit," which is mentioned above. We have additional information on this program at the patient's request.**

**I have read the above policies and agree to abide by them.**

**Signed: _____Date: _____**