ATLANTA CENTER
FOR ADVANCED PERIODONTICS

Practice Financial Policies

Thank you for choosing our practice as your dental healthcare provider. We are dedicated to delivering the highest quality care to help you achieve and maintain optimal oral health. To ensure a clear understanding of our financial policies, we ask that you review and sign the following statement prior to receiving treatment.

Payment Policy

As a non-contracted, out-of-network practice, payment is due in full at the time services are rendered. We accept a variety of payment methods, including cash, personal checks, all major credit cards, and CareCredit. If you are interested in financing, please speak with a member of our front desk team for more information.

Insurance Information

Although we are not in network with any dental insurance providers, we are happy to work with patients who have out-of-network benefits. As a courtesy, our office will file your insurance claims on your behalf and provide any necessary documentation to assist with your reimbursement. Please note that reimbursement will be sent directly to you by your insurance company.
Our goal is to make your experience as seamless and stress-free as possible, and we are here to help you navigate your insurance benefits to maximize your coverage.

Cancellation Policy

Our procedure and surgery appointments are carefully scheduled to allow sufficient time to accommodate the individual needs of our patients. We require at least 2 business days' notice for any changes or cancellations to scheduled appointments. When adequate notice is not provided, it limits our ability to offer that time to other patients in need of care. While we understand that emergencies can occur, we reserve the right to collect a cancellation fee of up to 20% of the total cost in advance for procedure and surgery appointments. For consultation and maintenance visits (including prophylaxis and periodontal maintenance), we require prepayment in full at the time of rescheduling.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY STATED ABOVE.

X_____

Patient Signature

***Please note: Returned checks will be subject to additional fees.**

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