We are honored you have chosen us for your dental care. In order to keep a completely professional and up front business relationship with our patients, we ask that you read and state that you understand our payment policy and our insurance policy. If you do not have dental insurance please skip down to the bottom of the page.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I understand that my insurance policy is a contract between my insurance company and myself. The contract is not between Dr. Scott A. Cohen and my insurance company. I know that I am fully responsible for all charges resulting from services rendered to me, including the balance remaining after payment of possible insurance benefits.

As a courtesy we will file all claims over $150.00 at no charge. For all claims under $150.00 there will be a $5.00 filing fee.

In instances where pre-determinations are approved, you may pay your co-payment and we will file for the remaining balance. However, if payment from your insurance company is not received within 30 days we will notify you of the balance due and your payment is expected in full at that time.

I understand that should my account become delinquent, I will be legally responsible for all cost involved with the collection of this account including all court cost, reasonable attorney fees and all other related cost as allowed under Georgia law.

Print Name Signature Date

All co-pays end payments are due at time of services. If any payment arrangements need to be made, please speak with the office manager prior to your appointment date.

Please understand that there might be a fee for any appointments cancelled without a twenty four hour notice.

Please sign and date that you understand and agree to our policy. If there are any questions please ask us before signing.

THANK YOU!!

Print Name Signature Date