Katherine L. Fry, DMD PC
Diplomate, American Board of Endodontics

Office Guidelines

Thank you for choosing Vinings Endodontics as your Dental Care Provider. We are committed to ensuring your treatment is a success! The following is a statement of our office guidelines, which we encourage you to read and sign prior to any treatment.

FINANCIAL POLICY

1. Payment in full at time of visit is due unless prior financial arrangements have been made.
2. We accept payment by Cash, Check, Visa, MasterCard, Discover or American Express. We have outside financing available including interest free plans with Approved Credit. We understand temporary financial issues may impact your ability to pay your account in a timely manner. If any issues arise, please contact our office as soon as possible so we can assist you with your account.
3. All returned checks will add a $30.00 fee to your account.
4. We believe everyone's time is valuable, therefore, ***there may be a fee charged for appointments canceled or rescheduled without at least a 48 hour notice.***
5. All major treatments require an appropriate down payment. To avoid misunderstandings, our Financial Manager will be happy to discuss any questions and/or financial concerns regarding fees and payments.

BILLING

An itemized statement covering all services received will be mailed on a monthly basis and will reflect the amount currently owed including any outstanding insurance. Please be aware that all unpaid balances are subject to interest at 18% APR after 60 days. Delinquent balances will be placed with a collection agency. The undersigned agrees to pay collection agency fees at (33 $^{1}/_{3}$%), attorney fees and court costs.

INSURANCE

As a courtesy, we will file your insurance claim for your treatment. Please keep in mind that your contract may include certain limitations. We encourage you to review your policy's coverage information and contact your insurance provider with any questions or concerns. Your insurance policy is a contract between you and your insurance company. We do our best to provide an accurate estimate for your dental treatment.

However, we cannot guarantee payment for your claims.

We allow 60 days for outstanding claims to be paid, after that time unpaid claim amounts are transferred to your personal balance and you are responsible for payment at that time.

Express Prior Consent to Contact Consumer by Cell Phone

You agree, in order for us to service your account or to collect monies you may owe, that Vinings Endodontics and/or the agents for Vinings Endodontics may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as is deemed applicable.

I/We have read this express consent and agree that Vinings Endodontics, its employees and/or agents may contact me/us as described above.

Responsible Party Signature_____

Date_____

MINOR CHILDREN

A parent or guardian must be present during a minor child's treatment. Occasionally treatment must change and we require permission from a parent or guardian before we proceed.

PLEASE READ THE FOLLOWING AUTHORIZATION AND SIGN FOR OUR FILES:

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

I have read all of the above and agree to all terms and policies as outlined.

Patient/Responsible Party Signature_____Date_____