ROCHELLE
FAMILY DENTISTRY

Michael Kristopher Frazier, DMD
229-365-0056
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Financial Policy

615 Second Ave.
PO Box 247
Rochelle, GA 31079

This is an agreement between Dr. Michael Kristopher Frazier, a Georgia Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Michael Kristopher Frazier.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:

1. You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.

Payment options if you have insurance:

1. You choose to pay your deductible of $_____ and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

(NEW!) Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. **(As of June 21, 2016 if your account (including any person linked to the account) has a balance of less than $500.00, account must be paid in full before being seated for dental procedures. If the account balance exceeds $500.00, a 10% balance must be paid on the account as well as the full amount for any dental procedures completed at the time of service. Any insurance payments for that day of service will be applied to the past due balance reflected on the account.) No exceptions.**

Contracted Insurance (in network): If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. Benefits verified by our office are only a quote of benefits and not a guarantee of payment. You are responsible for any portion not paid by your insurance company.

Non-contracted Insurance (out of network): Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. Benefits verified by our office are only a quote of benefits and not a guarantee of payment. You are responsible for any portion not paid by your insurance company.

Finance Charge: A finance charge fee of 1.5% will be imposed on each account that is over thirty (30) days past-due. We determine your account is past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Certified Letters: If you account becomes delinquent and we have to send a certified letter requesting payment, you will be responsible for a $10.00 certified letter charge.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $35) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree to pay any and all court fees incurred.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____