A. M. DeLoach DDS, LLC
d/b/a Smile Georgia! Dental
1113 Morningside Drive
Perry, GA 31069
478-224-5656

Office Policy

This office accepts PPO Insurance plans. By signing below you acknowledge that you are responsible for payment of all services rendered including any services and/or deductibles that your insurance does not cover. Our office will estimate the amount covered by your insurance as a courtesy only, but can in no way guarantee payment by your insurance company. If you would like to contact your insurance company directly for an estimate of coverage, based on the proposed treatment plan, you are encouraged to do so. Our office can submit a pre-treatment estimate to your insurance company, but please be aware that this will delay your necessary treatment. By signing below you authorize payment directly to A. M. DeLoach, DDS, LLC of the insurance benefits otherwise payable to you. You are ultimately responsible for all costs of dental treatment, whether or not we have estimated any payment by your dental insurance carrier. You hereby authorize release of any information, including the diagnosis and records of treatment of examination rendered to your insurance company.

Treatment plans are based on the Doctor's best estimate of the procedures that will be needed to treat/restore the problem area. Some procedures may need to be added or deleted to best restore your oral health. A treatment plan is offered only as an estimate of the procedures that will be completed.

PAYMENT IS DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH A MEMBER OF OUR OFFICE STAFF. OUR OFFICE ACCEPTS *CARECREDIT* ™ AND CAN ASSIST YOU WITH THE APPLICATION PROCESS IF YOU WISH.

OUR OFFICE REQUIRES A DEPOSIT ON SOME APPOINTMENTS, DEPENDING UPON THE LENGTH AND ESTIMATED COST OF TREATMENT. THIS DEPOSIT IS APPLIED AGAINST YOUR PATIENT BALANCE AT THE TIME OF TREATMENT BUT IS NON-REFUNDABLE IF YOU FAIL TO SHOW UP FOR YOUR APPOINTMENT WITHOUT AT LEAST 2 BUSINESS DAYS NOTICE.

OUR OFFICE RESERVES THE RIGHT TO CHARGE UP TO $50 FOR ANY OTHER MISSED APPOINTMENT WITHOUT 2 BUSINESS DAYS NOTICE. "FAMILY" APPOINTMENTS BOOKED TOGETHER ARE CHARGED A MINIMUM OF $50 IF MISSED WITHOUT 2 BUSINESS DAYS NOTICE REGARDLESS OF THE REASON.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name ______________________________ Date:__________________

Signature ______________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.