W. Jackson Garner, D.M.D., P.C.
1200 20th Street South, Suite 202
Birmingham, AL 35205

Thank you for choosing us as your dental health care provider. We are committed to serving you to the best of our abilities and assure you that your oral health is our chief concern. We will, with your assistance, develop a treatment plan that best serves your dental needs. Please understand that since oral disease is rarely life threatening, dental care is rarely a necessity. We, therefore, offer services for which there is a fee. We trust you agree that paying your bill is part of your dental plan. With this in mind, we provide the following Financial Policy that we require you read, agree to and sign prior to the start of any treatment.

Financial Policy

All patients (or their responsible party) must complete our "Financial Responsibility/Insurance Information" form, "Health and Dental History" forms and "Financial Policy" before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED.
We accept cash, check and Visa/MasterCard/Discover and most bank debit cards. We are listed as a provider for Blue Cross/Blue Shield, Delta Dental, Guardian, Metlife and United Concordia; we file most other insurance.

Regarding Insurance. If we accept assignment of benefits, the services we render will be filed with your dental insurance. If there is any question regarding your dental insurance or if we do not file for your dental insurance benefits, then payment for services rendered is expected at the time of your appointment.

The balance of your bill is your responsibility whether your insurance pays or not. We cannot bill your insurance unless you bring in all insurance information including the address, telephone number and group number for your dental insurance plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be pre-approved prior to beginning treatment. Please be aware that some and perhaps all of the services provided may be "non-covered" services and not considered to be reasonable and necessary under the terms of your dental insurance contract.

Regardless of the insurance company's determination of *usual and customary rates* or amount of assignment, you are required to pay the full amount charged.

UCR (Usual and Customary Rate). Our practice is committed to provide the best treatment possible for our patients. In addition, we use the finest commercial dental laboratories in the Southeast. With this in mind, we try to charge what is usual and customary for our area. By virtue of being a specialty practice and, therefore, treating complex cases outside the expertise of general dentists, some of our fees may be higher

than the usual and customary rates. Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are responsible for paying either your portion of the bill or the bill in full by the time services are complete.

Adult Patients. Adults are responsible for full payment at the time of services.

Minor Patients. The adult (parent or legal guardian) accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid for by cash or check or have been pre-authorized to an approved Visa/MasterCard/Discover or insurance company at the time of service.

Missed Appointments. No one's time is any more important than that of someone else. We have many patients who would like to have your appointment time. With this in mind, we reserve the right to charge for any missed appointment or any appointment not cancelled at least 48 hours in advance. The rate of charge will be no more than the average hourly rate for an office visit. In addition, patients who break (fail to report, cancel less than 24 hours in advance, etc.) three appointments will be dismissed from our practice.

Finance Charge. We reserve the right to charge an interest rate (of 18%) on any outstanding balance that has not been paid in full 90 days after treatment has been rendered.

Any outstanding balance beyond 120 days after treatment has been rendered will be turned over to our attorneys for collection.

We appreciate the time you have taken to read our Financial Policy. Please let us know if you have any questions or concerns.

I (we) have read, understand and agree to the above Financial Policy.

Patient or Responsible Party ________________________________ Date:___________

Co-Responsible Party ________________________________ Date:__________