Phillip S. Tully III, DMD, PC
(Dr. Phillip Tully III and Dr. W. Newton Sharp)
7270 North Lake Drive, Suite 100
Columbus, GA 31909

PATIENT FINANCIAL POLICY

Welcome to our office. We are honored that you have chosen us to aide you in achieving optimum dental health and are committed to providing you with the best care possible. Part of our care includes providing our patients with payment alternatives and informing them, in advance, of the cost of all dental care. Therefore it is necessary that our patients understand our financial policy.

It is the patient's responsibility to supply us with a copy of one's insurance card. Our insurance specialist will **estimate** the co-payment and deductible based on the information provided to us. This amount will be due at the time of service. The amount paid by the insurance company varies greatly and refunds will be made for any insurance overpayments. If however, they pay less, the patient will be billed for any difference and full payment is expected within 14 days.

Payment is required at the time services are rendered unless other arrangements have been approved prior to treatment by our administrative team. We accept payment for services in cash, check, major credit card, or care credit.

Once one is an established patient, we can hold up to 3 checks, one to be deposited each month, for no longer than 90 days. We can also charge the credit card once per month for no longer than 90 days.

We also accept Care Credit which is an outside credit card company that offers monthly payment plans. Some of the plans have deferred interest for 6 or 12 months.

Fees quoted for dental treatment are guaranteed for 180 days. However, when clinical conditions warrant a different treatment, a change in fee may be necessary.

Unpaid balances over 60 days will be charged interest in the amount of 1.75% per month or 21% annually.

A $25.00 fee will be charged for all returned checks.

All payments, regardless of the payment arrangements, are expected to be paid in a timely fashion. If payment for services is not received in a reasonable period of time, formal action will be taken. The patient is responsible for all applicable attorney and/or collection fees.

We require a **48 hour notice for all appointment changes.** Failure to notify our office may require a non-refundable $30.00-$100 deposit to be paid prior to any further scheduling.

I have read, understand and agree to uphold the financial responsibilities outlined in this policy and have been given the opportunity to receive a copy of this document.

Signature _____ Date _____