John F. Freemon, D.M.D., P.C. - 209 Creekstone Ridge

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, ______________________________ have been informed of this office's Notice of Privacy Practices.

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Print Name

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Signature

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Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

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John Freemon, D.M.D., P.C.

209 Creekstone Ridge - Woodstock, GA 30188 - (770)928-0871

Written Financial Policy

Thank you for choosing John Freemon, D.M.D., P.C . Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Check, Visa, MasterCard, American Express, Discover Card, Cash

  We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care for treatment plans of $400 or more. (Only if regular fees apply).
- NO INTEREST[1] Payment Plans[2] from CareCredit

  Allow you to pay over time with NO INTEREST[1]

  Convenient, low monthly payment plans[2] also available

  No annual fees or pre-payment penalties

Please note:

John Freemon, D.M.D.,P.C. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3] **However, any or all charges that may not covered by your plan is your responsibility.**

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I/We further agree to pay all costs of collections, including costs of a collection agency if the account is turned over to a collection agency.

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Patient, Parent or Guardian Signature   Date

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Patient Name (Please Print)

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2] Subject to credit approval

[3] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.