Martin & Rutledge
COSMETIC AND FAMILY DENTISTRY

OFFICE PROCEDURE AND POLICY

Thank you for choosing the office of Dr. Wayne T. Martin and Dr. Conor Rutledge for your dental needs. We are dedicated to helping you have a positive experience while visiting our office. We will be happy to help you with your insurance questions and concerns to the best of our ability. We are contracted with numerous insurance companies and will file with all companies except Medicaid and Tricare. This means we work with literally thousands of insurance plans. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your copays based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. We will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment but keep in mind, this will delay us in starting your procedures. It is important that you understand your dental policy and know it is intended to assist you with your dental expenses and rarely relieves you of all financial obligations. The accompanying adult of any minor treated will be responsible for full payment. We do not bill third parties. If the situation is due to a divorce or custody arrangement, we will bill the adult accompanying the minor.

You, the responsible party, will be responsible for all charges not covered by your dental plan. We file all claims electronically to help expedite payment from the insurance companies; this is done as a courtesy to all of our patients. Out of town visitors will be responsible for all charges on the date of service and you will be reimbursed if the visit is covered by insurance. We accept Visa, MasterCard, Discover, American Express, CareCredit, check and cash. **Any copays or deductibles are due on the date of service** unless arrangements have been made, in writing, with the office manager **prior** to treatment. All returned checks will incur a "Returned Check Fee" of $30.00. If the returned check is not paid in full within 10 business days, it will be turned over to The Baldwin County District Attorney's Worthless Check Unit. Any unpaid balances from treatment not paid in full within 30 days of the monthly billing cycle will have an interest rate of 18% applied to the last month's balance. In case of default Of payment, the responsible party agrees to accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. Responsible Party Initials: _____

Doctor / Hygienist Review: _____ Date: _____

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We will attempt to contact everyone prior to their appointment for confirmation because we have a specific amount of time reserved especially for you. While we understand illnesses and emergencies do occur, we ask that you give us 24 hours notice if you are unable to keep the appointment. If this becomes a common occurrence, we reserve the right to charge a fee for that appointment. By signing below, you are giving our office, or a representative of our office, permission to contact you by telephone at any telephone number associated with your account, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

You, the responsible party, agree to provide any changes in billing or medical history **before** each appointment. You acknowledge this office will keep all of your information confidential and will not release any information to anyone other than your insurance company, referring doctors, collection agents or those individuals listed on this form. You release authorization for this office to administer medications, perform diagnostic, photographic and therapeutic procedures as to follow the standard of care. You may ask us if you would like a copy of our privacy policy.

Again, we want to welcome you and your family to our practice and thank you for reading and understanding our office policy.

Name of Patient: _____Date: _____

Responsible Party:_____ Relationship to Patient:_____

Individuals we may release information to:

1._____

2._____

3._____

4._____

Doctor / Hygienist Review: _____ Date: _____

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