J. Michael Long, DMD, PC
2518 Loganville Hwy.
Grayson, GA 30017

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

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

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

_____

_____

_____

J. Michael Long, DMD, PC
2518 Loganville Highway
Grayson, GA 30017
(770) 237-2220

I, _____, give my consent to the office of J. Michael Long, DMD, PC to discuss with _____ all insurance information, as well as health/dental information.

_____ _____

Patient- Printed Date

_____ _____

Patient-Signature Staff Witness

J. MICHAEL LONG, D.M.D., P.C.

Financial and Insurance Policy

At the office of Dr. J. Michael Long, we strive to provide excellent care for our patients and are pleased to assist you with finances related to your dental care. All treatment fees are to be paid at the time of your appointment. If you have dental insurance we will be glad to assist you in filing the claim. Please be aware there is NO guarantee of payment from the insurance company. Any unpaid balance regardless of the status of any pending claim is the responsibility of the account holder. All account balances are aged based on the date of treatment.

_____ *Initial* Payment at the time of service is expected, including the amount that insurance is estimated not to cover. Our office accepts the following payment methods: Cash, Check, Visa, MasterCard, Discover and American Express.

_____ *Initial* When the patient's portion cannot be paid at the time of service and payments arrangements extend beyond 60 days, an interest rate per annum will be charged on all outstanding balances. A patient's payment history within our office will be taken into consideration when establishing payment arrangements.

_____ *Initial* A $30.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank on additional time. However, if funds are still insufficient, we will require payment via cash or credit card in the future.

_____ *Initial* Appointments broken or cancelled without sufficient notice are subject to a Broken Appointment Fee. Dr. Long request 2 business days notice for the change of any dental appointment.

_____ *Initial* Your account is considered delinquent if the requested payment is not received by the due date on the statement. If payment is not received, a late charge of $25.00 will be assessed and will appear on the next statement. Delinquent accounts may be sent to a collection agency. The patient and/or responsible part will be held liable for all collection fees and/or attorney fees.

We look forward to serving your dental needs. If you have any questions concerning this policy or to schedule an appointment, please contact us at 770-237-2220

I have read and understand my financial responsibilities under this policy and agree to pay all charges for services rendered, and to be bound by the terms set forth.

Signed _____ Date _____
Patient (age 18 and above) Parent or Legal Guardian

I authorize the release of any information to process insurance claims.

Signed _____ Date _____
Patient (age 18 and above) Parent or Legal Guardian

I authorize payment of benefits directly to J. Michael Long, DMD, PC

Signed _____ Date _____
Patient (age 18 and above) Parent or Legal Guardian