

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Understanding your insurance coverage can be challenging! Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage that fits the company budget. Each plan is slightly different with lower premium plans covering few services and lower fees for services. We encourage you to become familiar with you policy exclusions, deductibles and required co-payments.

**Dental insurance is a contract between the employer and the patient. It has no connection at all to the provider of dental treatment.**

We will make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance claim forms as a courtesy to our patients. We will also provide a treatment plan with the best estimate we can provide at the time that will show expected insurance reimbursement and patient share for every procedure. Should our estimate of the patients share be too high, a refund will be made to the patient, likewise, if the estimate was too low, the remainder will be due at the time of payment from the insurance company.

Should no insurance payment be made within 45 days of a submitted claim, we do ask that you call the insurance company and find out why. If the claim is not paid within 60 days the fee will become the sole responsibility of the patient.

A service charge of 1.75% per month on the unpaid balance, after insurance pays, will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

Treatment Fee's are valid for 90 days from the date presented and are subject to revision. Treatment could be altered if your dental needs change during treatment. The patient would be notified of any change(s) in treatment.

The estimated insurance coverage is an estimate only, no insurance company guarantee's payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment Options: Cash, Visa, MasterCard, Amex, Discover, Debit Cards. We also offer six months financing with no interest through Care Credit pending approval.

I further agree that a waiver of any breach of any time or condition shall not constituted a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

**I have read the above conditions of treatment and payment and agree to their content.**

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Signature of patient, parent or guardian                      Date                      Relationship to patient:

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Signature of guarantor of payment/responsible party                      Date                      Relationship to patient:

Dr. Richard E. Williams  
14 Piedmont Center, Suite P80  
Atlanta, GA 30305  
404.237.3309

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### NOTICY OF PRIVACY PRACTICES

**Purpose:** This form, Notice of Privacy Practice, presents the information that federal law requires us to give our patients regarding our privacy practices. The Health Insurance Portability and Accountability Act encompasses significant instructions and requirements regarding the control of personal health information. The prevailing sections of the act are commonly known as HIPPA "Privacy Rule". The rule mandates that numerous precautions be taken and safeguards put in place to protect our patient's personal health information.

#### Uses and Disclosures of Health Information

**Treatment:** We may use your health information about your treatment or disclose it to a dentist or physician or other health care provider providing treatment to you.

**Payment:** We may disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another healthcare provider or entity that is subject to the federal privacy rules for its payment activities.

**Appointment Reminders:** We may disclose your health information to provide you with appointment reminders (such as voicemail messages detailing necessary re-operative instructions).

**To Your Family or Friend:** We may need to disclose your health information to a family member or friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure.

We must provide notice to each patient and we must make good-faith attempt to obtain written acknowledgement of receipt of the notice from the patient or guardian. We must also have the notice in our office in clear and prominent location where it is reasonable to expect patients seeking service from us to be able to read the notice. Whenever the notice is revised, we must make then notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the notice to each new patient at the time of the service delivery and to any person requesting a notice.

By my signature, I acknowledge the Notice of Privacy Practices that federal law requires Dr. Richard E. Williams, D.D.S., to provide all patients regarding our privacy practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_