JON PRESTON SIMMONS, D.M.D.

Family Dentistry

205 West Orange Street, Jesup, GA 31545

Office Hours: Monday thru Thursday by Appointment

Telephone: (912) 427-2333 Fax: (912) 427-0898

APPOINTMENTS:

If you are unable to keep an appointment we need 24 hours notice. We reserve the right to not reschedule a missed appointment.

—PAYMENT NOTICE—

PAYMENTS:

PATIENTS WITH NO INSURANCE:

(1) Payment is due when services are rendered.

(2) We accept cash, check, Visa, MasterCard, Discover and American express.

PATIENTS WITH DENTAL INSURANCE

(1) Your estimated part not covered by the insurance company is due each visit.

(2) After the insurance company has paid, you will be sent a statement for any unpaid balance.

(3) If your insurance company has not paid this office within 30 days of service, you will be responsible for payment. Please remember, your insurance policy is a contract between you and the insurance company. As a courtesy and at no charge, we are happy to file your insurance for you, but please do not hold this office responsible for your insurance company's inability to be prompt in their payment to us. All accounts are due and payable within thirty (30) days.

(4) If your insurance company denies a claim because they decide a procedure we performed is medically or dentally unnecessary, you agree to be responsible for the entire claim amount.

DELINQUENT ACCOUNTS/ INSUFFICIENT CHECKS:

A $20.00 fee will be charged on all returned checks.

A 14 % interest rate will be added to all unpaid balances over 30 days, with a minimum charge of $1.00.

The parent or guardian who accompanies a child is responsible for payment at the time of service.

I agree to pay for all services rendered in accordance with the terms and conditions set forth in the Office Policy of Jon P. Simmons, DMD, LLC. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all reasonable attorney's fees, additional collection agency fees and court costs incurred.

______________________________ Patient's Name (Print)

______________________________ Responsible Parent or Guardian's Name

______________________________ Patient's Signature or Guardian

______________________________ Today's Date and Telephone Number

I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NEEDED TO PROCESS THE CLAIMS ON ALL CHARGES AND PERSONS ON MY ACCOUNT. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO:

JON P. SIMMONS, DMD, LLC, FOR DENTAL SERVICES RENDERED.