TOOTH MECHANIX
Gary E. Chike DMD, MS
5328 Lanier Island Parkway
Buford, Ga 30518
678-765-2765

Insurance - Financial Agreement

I understand if I have insurance that it is my responsibility to pay any deductible amount, co-insurance or any other balance left not paid by my insurance. I understand that my insurance company cannot guarantee payment until they have received and reviewed and determined that it is a covered benefit. Some services may be deemed non-covered or not medically necessary by insurance. If so, I understand I am directly responsible for the charges incurred. I authorize the release of information necessary to process my dental claim and authorize payment directly to Gary E. Chike DMD PC (dba TOOTH MECHANIX).

In the event my account is placed with a collection agency, a collection fee in the amount of 25% of the then outstanding balance may be added to my account and shall become part of the total amount due. I understand I will be responsible for all collections including attorney fees and court costs.

I understand that for TOOTH MECHANIX to service my account or to collect any amounts that I may owe, TOOTH MECHANIX and their collection agencies may contact me or family members if I have a family account, by telephone at any telephone number or email associated with my account, including wireless telephone numbers which could result in charges to me. TOOTH MECHANIX and their collection agencies may also contact me by sending text messages or emails, using any email address that I have provided. Methods of contact may include using pre-recorded/artificial voice messages and / or use of an automatic dialing process as applicable. Acceptable forms of payment. Cash, MC/Visa, Discover, American Express and CareCredit.

ANY Pre-Payments made are an agreement for dental treatment and are non-refundable after 7 days. ALL SALES ARE FINAL.

I have read and fully understand the above information.

Print Patient Name: _____ Date_____

Signature: _____ Date: _____

Signature of Patient or Legal or Guardian:

_____ Date: _____

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No Show and Cancellation Policy

Please understand our appointment times are scheduled to allow us to take care of each individual patient's needs. We maintain a "No Show"/ Cancellation Policy" for all patients. We require a 48-hour advance notice for any canceled or rescheduled appointment (minimum 2day). ALL cancellations must be made during normal business hours.

Surgery appointments requiring more than two hours require a deposit and a 1-week cancellation notice.

Appointments are required to be confirmed. If you do not confirm or you are late to your dental appointment, we reserve the right to cancel the appointment. If more than two appointments are missed a deposit will be required to schedule future appointments.

If an appointment is missed or canceled with less notice, the following charges will apply:

- $100 for one-hour appointments
- $200 for one and a half hour appointments
- $350 for two-hour appointments

I have read and fully understand the above information.

Print Patient Name: _____Date: _____

Signature: _____ Date: _____

Signature of Patient or Legal Guardian:

_____ Date: _____