Dr. George D. Mason, D.D.S.
Dr. Luke Thompson, D.D.S
Dr. Lucelia Lima, D.D.S.
Dr. Michelle Ireland, D.M.D.
1213 N. Main Street
LaFayette, GA
706-638-1114

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

Our office is happy to assist you by filing your insurance claims; however, dental benefits quoted by your insurance company or by us are never guarantees of payment until your claim is actually processed. We require that you pay your estimated patient portion at time services are rendered.

Our office is not a network provider or contracted with any insurance company, therefore we do not offer any adjustments, discount or write-offs.

I understand that I am financially responsible for any amount not paid by my insurance company. I hereby authorize payment directly to Dr. George D. Mason's office, all insurance benefits otherwise payable to me for services rendered. I authorize the above establishment or provider to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Name _____

Patient's Signature _____ Date _____

Signature of Responsible Party if a minor _____ Date _____

- Outstanding balances on your account are discouraged and must be cleared before the next appointment or within 30 days of treatment. Any amount due and not paid within 30 days will be charged interest at a rate of 1.5% per month. Delinquent balances over 90 days old will be referred to Brown Collections Agency of Chattanooga. All referred accounts are marked inactive and no appointments will be made until the balance is resolved through the collection company.
- A returned check fee of $35.00 will be added to your account for any returned check.
- Your dental appointments are scheduled carefully. We request 24 hours advance notice for rescheduling. Your account will be charged a $35 broken appointment for repeated missed appointments.
- I understand and accept the financial and the dental insurance policies listed above and I have had any and all my questions answered to my satisfaction. I agree to pay for all treatment.

Signature _____ **Date** _____