Abercorn Family Dentistry
Ann Linton, DDS PC
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PERSONAL GUARANTEE CONTRACT

PLEASE READ CAREFULLY!

The office of Abercorn Family Dentistry & Ann Linton DDS PC offer patients the courtesy of filing insurance claims on their behalf. However, due to the complex nature of medical billing, it sometimes becomes necessary to seek payment directly from the patient. This contract is designed to outline both parties responsibility in the collection process. This is a legally binding contract and shall be enforced under the laws of the state of Georgia.

OFFICE RESPONSIBILITIES

The office of Abercorn Family Dentistry & Ann Linton DDS PC shall use reasonable efforts to correctly and timely file insurance claims on my behalf for services and materials rendered.

1 .The offices shall promptly respond to requests from insurance carriers for additional information in order to minimize processing times.

2. The offices intend to collect and archive credit/debit card data for the purpose of securing payment for all services rendered. All financial information shall be held within our encrypted, HIPAA compliant patient database and used, according to this contract for the sole purpose of collecting outstanding balances.

3. Upon written request, the offices shall provide documentation of all collection efforts.

PATIENT RESPONSIBILITIES

Failure to abide by any term of this agreement may result in termination of the claim filing process; all fees becoming due and payable immediately.

1. Patient agrees to provide *complete* and *accurate* insurance information at the time services are rendered. All co-payments, coinsurance, deductibles, and cash-based amounts are due at the time of your appointment. If your insurance requires a referral or authorization for your visit, we will make every effort to obtain one for you but it is your responsibility to make sure you're referral and authorization has been obtained as directed by your insurer.
2. Patient agrees to notify the offices Abercorn Family Dentistry & Ann Linton DDS PC of any change of address or telephone numbers.
3. Patient agrees to pay in full any and all charges outstanding after **120 days** from the date of service regardless of the reason for denied or delayed payment.
4. Returned checks are subject to a $35.00 fee.
5. Patient agrees to authorize Abercorn Family Dentistry & Ann Linton DDS PC to charge debit/credit cards on file in order to resolve outstanding or unpaid balances Abercorn Family Dentistry & Ann Linton DDS PC reserves the right to deny services, excluding emergency dental services to patients failing to execute this Personal Guarantee Contract. ________(Initial Here)
6. In the event your account is assigned to an outside collection agency, patient/responsible party agrees to pay the following fees.

Collection Fee: 40% of amount assigned to collection agency. **Interest: 2% per month on the balance due**.

ASSIGNMENT AND RELEASE

I hereby authorize Abercorn Family Dentistry & Ann Linton DDS PC to furnish my information to insurance carriers and herby assign Abercorn Family Dentistry & Ann Linton DDS PC all payments for dental services rendered to myself and dependents.

By my signature below, I acknowledge that I have read and that I understand the above statements and I am willing to accept responsibility to pay for services rendered if my insurance does not cover them. I also understand that this authorization does not expire.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ____________________

Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient