

# *Alpharetta Aesthetic Dental Studio*

*Dr. Stephen P. Leafe, D.D.S.*

*30 Milton Avenue Alpharetta, GA 30004*

*Phone: 770-475-9630 Fax: 770-475-7038*

## Appointments

- *Our appointment schedule is arranged to respect your time and convenience. We make every effort to see you at the appointed time, and in return, we appreciate your promptness and consideration in not changing scheduled appointments. However, if you do need to change an appointment, **a 48-hour advance notice is required.** Any appointments canceled without a 48-hour notice will be charged a minimum of 20% of the services you were scheduled for that day, depending on the amount of time reserved for your appointment.*

## Insurance

- *We are happy to assist you in obtaining maximum benefits with your insurance carrier. As a courtesy to you, we will file your claims and we ask that your insurance company make directly to our office. Due to the ever-rising cost of billing, the estimated patient's portion for services rendered is due the day that they were performed. If insurance payments are not received within 30 days, you must pay the entire balance and obtain reimbursements directly from your insurance carrier. Insurance companies do not pay for all dental services, and we perform services according to your need. Although we do call and get a break down of your dental coverage, it is ultimately your responsibility to be informed about your specific dental coverage. Any questions about your coverage should be directed to your insurance company.*
- *If you have secondary insurance coverage, we will be glad to assist you in filing your claim to them, but you will still be responsible for your co-pay and any services that are not covered by your primary insurance carrier. We will then have your secondary insurance carrier reimburse you directly.*
- *If an insurance company is contracted to reimburse the patient only and not the dentist, payment will be due at the time that services are rendered.*

## Payment Plans and Billing

- *There will be a \$3 or 2% service charge (whichever is greater) on any balance over 60 days. If your account is turned over to a collection agency or attorney, you the undersigned, agree to the addition of reasonable collection, attorney fees and court costs incurred to collect the outstanding balance. I understand and agree that I am responsible for the payment of all charges regardless of any insurance coverage or other plans available to me.*

## Consent

- *The undersigned hereby authorizes Dr. Leafe to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Leafe to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Leafe to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Patient's Name) \_\_\_\_\_ and further authorize and consent that Dr. Leafe choose and employ such assistance as he deems fit. I also understand the use of aesthetic agents embodies a certain risk. I understand the responsibility for payment for dental services provided in this office for myself or my dependent(s) is mine, due and payable at the time services are rendered. If insurance is provided, the patient's share is due at the time of service. I have read and understand this statement.*

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**Date**

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**Signature**

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**Relationship**