

# Pullen Comprehensive and Cosmetic Dentistry

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## EXPLANATION OF OFFICE POLICY

Thank you for choosing Pullen Comprehensive and Cosmetic Dentistry as your dental provider. We are committed to providing you and your family with the best available care. In our ongoing process to meet your dental needs, our billing department will be available to discuss our fees and policy with you as needed.

We ask that all responsible parties read and sign our financial policy and complete the patient information forms prior to seeing the dentist.

All patients need to understand that all services furnished are charged directly to the patient and that he or she is responsible for the bill. As a courtesy to our patients we will file to most insurance carriers; however, we cannot render services under the assumption that charges will be covered by your insurance company. We strive to provide the best dental treatment according to the patient's needs regardless of insurance coverage.

I hereby assign and request that payment of all dental benefits be made to the providers of Pullen D.M.D., P.C. I authorize the release of all medical and other information that is necessary to process claims. I understand that I am financially responsible for any and all non-covered charges incurred while under the care of said dentist, including co-payments and deductibles according to how my particular insurance plan specifies.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit. As a courtesy to you, it is the policy of Pullen Comprehensive and Cosmetic Dentistry to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(Please read and initial each of the following)

\_\_\_\_ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to the contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charge. As your dental provider, we will only supply factual information to facilitate claim processing.

\_\_\_\_ 2. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within (60) sixty days, the balance will be due in full from you. Our office finance charge is 24% for and outstanding balance. If any payment is made directly to you for services billed for Pullen Comprehensive and Cosmetic Dentistry, you recognize an obligation to promptly remit payment to Pullen D.M.D., P.C..

\_\_\_\_ 3. Accounts that become delinquent must be paid in full before any family member is seen. If account is for a juvenile, then the responsible party will be sent to collections. I agree to be responsible for all cost of collection, including but not limited to a reasonable attorney's fee and court costs.

\_\_\_\_ 4. There will be a \$25.00 fee for any appointment that is cancelled or missed without a twenty-four hour notice. Exceptions can be made with authorization from the doctor only. ( Three missed appointments can be reason for dismissal)

At Pullen Comprehensive and Cosmetic Dentistry, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (256)-533-3735.

I understand the above information and will be responsible for the patient listed below.

Printed Name of Patient:

\_\_\_\_\_

Patient Signature and/or Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_ acknowledge that I have received a copy of the Notice of Privacy Practices from Pullen D.M.D., P.C.

The following individuals have my authorization to access my Protected Health Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone: \_\_\_\_\_