Michael R. Callahan, D.M.D., P.C.
12991 Jones St.
Lavonia, Georgia 30553
706-356-1477

I understand that I am financially responsible for all charges. **Payment is expected as services are rendered.** We accept cash, check, debit card, Master Card, Visa, or payment options through Capital One or HelpCard upon credit approval.

I understand that the treatment plan and fees given to me at any time are only **guaranteed for 6 months.**

I understand that I must give a **24-hour notice or there will be a charge on any unexcused broken appointments.**

ABOUT YOUR INSURANCE:

We will be happy to help you with any insurance questions. We will also help you to receive the maximum benefits under your policy.

But please remember that YOU ARE RESPONSIBLE FOR PAYMENT. Remember, too, that no insurance company will cover ALL dental costs. It is your responsibility to pay any deductible, co-insurance, or other balance not paid for by your insurance company. If your insurance does not pay within 30 days the account will automatically begin to accrue interest. This will be noted on your monthly statements. Let us know if there is a problem that you are aware of with your claim status, so we can help you to resolve it as soon as possible. (Some insurance companies are just slow payers.) **In the event that your insurance company does not acknowledge your claim within 45 days, you will be responsible for the balance in full.** We **will provide you with all necessary documentation that will aid you in recovery of your benefits.**

Your insurance is an agreement between you and the insurance company only. We prepare and send your insurance claims as a service to our patients. We try to make insurance as simple and convenient for you as possible in this way.

I understand that in the event my account becomes thirty (30) days past due and is turned over to United Collection Firm of Georgia, Inc. that I will be responsible for all collection expenses incurred.

Thank you,

Dr. Michael Callahan

_____
Signature Date

I have been informed of HIPPA and the privacy of my records.

_____
Signature Date