Cool Springs
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Brentwood, TN 37027

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Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval.

In the event a check is returned for insufficient funds, your account will be charged.

All account balances over 180 days are subject to collection placement. If the account is referred to an outside collection agency, I agree to pay all costs, including attorney fees, up to the statutory limits. Interest charges may be applied

Do you have Dental Insurance?
We make every effort to assist patients in submitting claims. The estimated co-payment is due in full at each appointment. When payment is received from your carrier, you will receive a statement for any outstanding balance or be reimbursed for any overpayment.

Unpaid claims more than 90 days old are the responsibility of the patient. We will continue to assist you in being reimbursed by your carrier.

Minors accompanied by parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment is responsible for full payment at time of service.

Unaccompanied Minors: Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment (s) and Cancellations:
Our goal is to provide treatment in a timely manner with as few visits as necessary. To provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or canceled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Consents:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I authorize all necessary X-rays, Study Models, and other diagnostic aids as needed to make a thorough diagnosis and proper care by the Dentist. Similarly, I authorize all recommended and agreed upon treatment. I also authorize the use of anesthetics (as needed) and I am fully aware that using anesthetic agents involves certain risks.

Patient Authorization Signature: The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for the benefits for services rendered or for services to be rendered on my behalf.

I agree to pay Cool Springs for any services rendered to me or members of my family in accordance with the terms stated above. Interest charges will be applied to accounts not paid in accordance with the above guidelines at a rate of 1.5% monthly for a compound annual rate of 18%.

I have read the above information regarding the Office Agreements and agree to its terms.

_____

Signature

_____ _____

Patient or Parent/Guardian Date