Office Financial Policy

Fees & Insurance Coverage

You are responsible for all charges incurred for treatment rendered. Our office will file charges with your insurance company, provided assignment of benefits is directed to Piedmont Dentistry. If you have questions concerning your dental insurance coverage, please contact your employer or insurance company for details.

Your initial visit will require x-rays of diagnostic quality for Dr. Williams to make a accurate diagnosis.

All patients are presented an estimate for fees in writing prior to treatment that will be honored for 90 days. Because dentistry is not an exact science, the nature and complexity of a procedure can change once treatment has been initiated. If this occurs, you will be informed of the necessary procedural change and the fee will be adjusted accordingly.

As a service to you we will submit an estimate of dental benefits to your insurance on your behalf prior to treatment. The purpose of the estimate of benefits is to assist with providing you with an accurate "co-pay" amount that is to be paid at or before the time of service.

Financial Options

For your convenience we accept; Cash, Visa. MasterCard, Discover & American Express.

Emergency Appointments

New & established patients will be charged a fee for emergency appointments. If your insurance can be verified at or before the time of your visit, a claim will be filed with your insurance and you will be required to only pay a co-pay at the time of service. If you do not have insurance, the total fee for the examination and any treatment provided will be due at the time of service.

Delinquent Accounts

If a balance remains on your account beyond 45 days of service, regardless of pending insurance payment, you are responsible for full payment immediately. If your account is delinquent beyond 60 days of service, it will be turned over to a collections agency.

By signing this form you are stating that you have read and understand the following policy and agree to all of its conditions.

_____ _____

Signature of patient, Guardian of patient or Parents Authorized Representative Date

_____ _____

Witness Date