Dr. James Kennedy
2784 N. Decatur Rd. Suite 110
Decatur Ga. 30033

Dear Patients,

We feel that all patients deserve from us the very best dental care we can provide. Further, we feel that everyone benefits when definite financial arrangements are agreed upon.

In order that we may have a definite understanding regarding the payment of dental fees, we require that the patients portion of fees be paid in full at the time of service. We do not offer any payment plans, though we can help you apply for Care Credit. (dental credit card) We also accept checks, cash or any major credit card.

You must also understand that you are responsible for the payment of any charges which your insurance company states are your responsibility. Any outstanding account balance after dental insurance payment is your responsibility. We will submit your claim to your insurance company and do everything possible to seek full payment, but be aware that many insurance companies are passing more costs onto the patient. Those costs are your responsibility.

In event your account becomes 60 days past due, you will be assessed a monthly late fee of $10.00 per month until paid in full.

There will be a $50.00 charge for failing to cancel an appointment without giving a 24 hour notice; also any broken appointment will be charged $50.00. This gives us the ability to schedule another appointment.

On _____, I _____ have read and understand the
Date Name (print)
payment policy of Dr. James P. Kennedy.

Signature,_____