KATHY A. HUBER, DDS
2023 Grayson Hwy, Ste 203
Grayson, GA 30017
(678) 226-4466

Our first priority is providing our patients with the highest quality of care and service.
We accept cash, local checks, MasterCard, Visa, AMEX and Discover for payment of your charges at the time of service. We also offer Care Credit (Medical/Dental Credit Card) if the above methods are not available for you.

Returned checks will receive a charge of $25.00 per check. In addition, accounts that are 60 days or more past due will receive a $10.00 billing charge per statement period, and will accrue interest at 1.0% per month. Our office requires 48 hours notice to cancel or reschedule any appointments. This allows us to treat other patients in need of our services, improper notice will result in a $50 charge for hygiene and 25% charge of your appt with Dr. Huber.

If you will be using insurance, we will assist you in submitting your bill for services rendered. Please keep in mind that your insurance coverage is a contract between you and the insurance company, not between our office and the insurance company. Therefore, you are ultimately responsible for payment for all services received, regardless of whether your insurance company pays or denies your claim. **If your claim remains unpaid after 90 days, we will close the claim and the outstanding balance will be your responsibility in full.**

If your insurance company's policy is to send the check to the subscriber (patient) instead of the provider, you will be responsible for your charges in full at the time of service.

If necessary, a collection agency, attorney or small claims court will take over a delinquent account. If your account is placed with any of the aforementioned agencies, you will be responsible for all collection costs and attorney's fees, in addition to the cost of services received.

I give permission for my dentist and her clinical team to take any necessary diagnostic films, photos or study models to properly enable complete diagnosis and treatment.

I have read and understand my financial responsibilities under this policy and agree to pay all charges for services rendered, and to be bound by the terms set forth. I assign dental benefits to be paid directly to Dr. Kathy Huber from my insurance company.

_________________________________ _________________________
Patient/Responsible Party Signature **Date**

_________________________________ _________________________
Printed Name **SS# Patient/Responsible Party**