PATIENT TREATMENT AND FINANCIAL POLICY

Thank you for choosing River Pines Dental as your dental healthcare provider. We are committed to providing you with the highest quality dental care.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover.

Please note: Additional fees will be applied for returned checks. All account balances that are past due are subject to a late fee. In the event of non-payment, the patient is responsible for any collection and or legal fees associated with collection of balance due. The collection fee is 40% of the total balance.

Do you have insurance?

■ As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

■ All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

■ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

■ We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

■ We ask that you pay the patient portion for all work not covered by insurance at time of service. We accept cash, check, MasterCard, Visa, and Discover. Effective January 1, 2023, we will impose a

surcharge of 3.5% on the transaction amount when paying with a credit card, which is not greater than our cost of acceptance. *Please note-River Pines Dental DOES NOT profit from this fee*

■ Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

■ We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

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

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency 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. In order to provide the best services to our patients, we require at least a 24-48-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 $50 charge will be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice. There is a $50 charge for no call no show appointments.

Consent:
By signing below, I am stating that 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 due and payable at the time services are rendered.

Patient /Parent name:_____ **Date of Birth:**_____
Dependents: _____ **Date of Birth:**_____
_____ **Date of Birth:**_____
_____ **Date of Birth:**_____
_____ **Date of Birth:**_____
_____ **Date of Birth:**_____

Patient /Parent signature:_____ **Date:**_____