River Valley Dental Office Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

GENERAL:

Understand that regardless of any insurance coverage, you are responsible for the balance due of all professional services rendered on your account. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 24 business hours in advance, you may be charged $50.00. Please help us service you better by keeping scheduled appointments. Repeated abuse of our cancelation policy may result in dismissal from our office.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **It is your responsibility to contact your insurance company and inquire what benefits you have.** We will provide you with an estimate for services however, if you have any questions concerning any fees for service, it is your responsibility to have these answered prior to treatment with your insurance company.

Please be aware some or perhaps all of the services may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion 45 days from time of service.

PAYMENT:

Full payment is due at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service. We accept cash, personal check, and all major credit cards for payment as well as third party financing. Please note a return check fee of $25 will be applied to your account for any returned checks not able to be processed.

Unpaid balance over 60 days old may be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent-past 120 days, the patient may be responsible for payment of third-party collection efforts with a 35% recovery fee, attorney's fees, and court costs incurred with the recovery of the monies due on the account.

By signing the Financial Agreement, I understand and agree to the terms and conditions of this agreement. You also authorize us to receive payment from your insurance.

Signature: _____ **Date:**____/____/_____

Name Printed: _____