RIVERSIDE DENTAL ASSOCIATES, L.L.P.
FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful.

Patients with insurance

We ask that you complete our Information and Insurance Form before your appointment. As a courtesy to you, we will submit all claims either electronically or manually to your insurance company. We will accept assignment of insurance benefits. You will be responsible for any co-pay or deductible that may or may not exist. A 60 day grace period will be extended to allow your insurance company to respond to your claim. Any balances past 60 days can be paid with a preauthorized credit card.* Any balances not paid after 60 days will be subject to a monthly finance charge.

Please note that your insurance policy is a contract between you and your insurance company. We will assist you in any way we can to simplify insurance matters. If you have special needs we can arrange an appointment with our financial coordinator to set up a comfortable payment arrangement.

Patients without insurance

Payment is expected at time of visit. We understand there may be extenuating circumstances. If so, please advise us. We accept cash, checks, Visa, Mastercard, Discover, and American Express. Financing of larger cases is available through CareCredit, subject to approval. Other financial arrangements may be possible through an appointment with our financial coordinator.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I agree to be responsible for payment of all charges for services rendered to me regardless of whether those charges are covered by insurance. I agree to pay a service charge at the rate of one and one-half percent (1.5%) per month on any past due balance, as well as all collection costs and reasonable attorney's fees if I fail to pay and these costs are incurred. If the patient is a minor, payment may be sought from both of the minor's parents, regardless of custody, divorce or separation agreements.

X____ Date ____________________

Signature of Patient or Responsible Party

***Patient Easy Pay Consent**

I authorize Riverside Dental Associates, L.L.P. to charge my payment card for the balance of fees not paid after 60 days from the date of service.

Credit Card ____________________ **Name on card** ________________________

Credit Card Number ____________________ **Exp date** ________________________