FINANCIAL POLICY

Thank you for choosing RK Dental. We are happy to welcome you as our patient and look forward to offering you and your family the finest dental care available. Providing complete comprehensive dental services includes discussing all treatment and financial information. Please review this policy in full.

- **Payment is due** at the time services are rendered. For your convenience we accept cash, checks, and major credit cards, such as Visa and MasterCard. We will extend a **5% accounting courtesy** for cash or check payments over $1,000 that is paid in full prior to the treatment.
- Insurance / dental plan often **does not** cover all the costs involved in treatment. We will work to maximize your dental plan benefits. However, you are expected to pay for services rendered if we are unable to verify your insurance information before treatment.
- We will do our best to give you a **rough estimate** of your investment in your dental health for each upcoming visit, based on your individual treatment plan and insurance coverage. However, this is just an estimate as we do not have control over insurance coverage and payment.
- Any **deductible** or **estimated co-payment** amount will be due at the time of treatment.
- **Emergency visits** by patients new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.
- **Insurance payments** are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- **Payment plans** and **financial arrangements** are available for comprehensive dental treatment. Please speak with us to make arrangements prior to commencing treatment.
- **Appointment cancellations** without sufficient prior notice will incur cancellation fee. Please refer to Appointment Cancellation Policy for details.
- **Returned checks** are subject to a **$35.00** fee and all account balances **over 90 days** may incur finance charge at the rate of 1% month (12% annually).

I understand and accept the above policy.

Patient /Parent Signature: _______________________________ Date: ______________

Patient /Parent Name (PLEASE PRINT): ____

For Patients with Dental Plan Benefits:

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with dental claims. I hereby direct payment of the dental benefits otherwise payable to me, to the treating dentist or legal entity.

Subscriber/ Responsible Party Signature: ____________________________ Date: _____________