# Financial Agreement Form

RK DENTAL CARE
HEALTHY SMILES FOR LIFE

## 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 and let us know if you have any questions, or concerns.

- 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.
- 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.
- 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).

**Do You Have Insurance?**

- 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, your employer, and your insurance company.
- As a courtesy to you, we will help you process your 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. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. 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.
- 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.
- We ask that you pay the deductible and co-payment, which is the ***estimated*** amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- 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.

**Consent:**

I have read, understand and agree with the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to the treating dentist or legal entity. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. 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.

Patient's First Name *

Patient's Last Name *

Responsible Party Signature *

Today's Date

08/11/2023