Riversbend Dental

6028 S. St Rt. 48 Maineville, Ohio 45039

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our Financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patient's financial capabilities your full understanding of the content of this form. If any time you do not understand any part of this document please do not hesitate to ask, we will do our best to explain any material which is unclear.

Payment

Payment in full is due time of service unless prior financial arrangements are made. We offer several payments options, including:

1 .We accept Cash, Checks, Visa, MasterCard, Discover and American Express.

2. We offer pre-payment cash discounts

3 .We offer monthly payment plans in accordance with the office credit guidelines.___

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Insurance

Our office is committed to helping out patients maximize their benefits. As you may be aware, medical and dental insurance is becoming increasingly complex. We are always available to answer your questions, however, your insurance policy is a contract between you and your insurance company and as a medical provider, we are not party to that agreement. The patient portion of your bill must be paid at the time of service. We ask our patients to provide us with complete dental insurance information. As a service to our patients we will bill insurance companies for services and allow 45 days to render payment in full. After 60 days, you are responsible for the entire balance which is due in full upon request. Insurance policies vary considerably; therefore we try to estimate your coverage in good faith but cannot guarantee coverage or payment amounts by your insurance company. This is an estimate only.

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Minors

Payment of service for treatment of minors is the responsibility of the adult accompanying that minor at the time of service unless prior arrangements are made.

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Missed Appointments

Once you have made an appointment, please remember that this time has been reserved specifically for you. We are aware how important your time is. Please be respectful of all our other patients. If there is an unforeseen delay in your schedule which will cause you to be late please call the office at your earliest possible convenience. We will do our best to accommodate you. If you should cancel your appointment please kindly give **48 hours** notice. If you should have to cancel on short notice or miss an appointment without calling, we do reserve the right to charge a cancellation fee. The minimum charge for cancellation or not attending a scheduled appointment is $ 25.00. Appointments longer

than 60 minutes and multiple missed appointments may result in a higher cancellation fee. RBD reserves the right to terminate out relationship with a patient(s) who repeatedly do (es) not follow out guidelines regarding scheduled appointments.

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Initial

Service Charge

It is the policy of this office to charge a 1.5 monthly (18% annual percentage rate) fee with the minimum $2.00 to all accounts which are over 60 days past due. We will charge a fee of $ 35.00 for each returned check.

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Collection Fee

All though we try our best to minimize the use of outside sources to aid in the collection of fees incurred in our office, on some occasions it is necessary for us to utilize such a company. Any account that is over 60 days past due may be scheduled for collection. If an account is referred to a collection agency for retrieval of payment, any discounts and/or previous professional adjustments given will be forfeited by the patient and these monies will be added back onto the account. In addition, all expenses relating to such collection will be charged to the person with financial responsibility for the patient's account. The minimum fee charged for collection of an account is $25.00.

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Financial Consent

The patient (or person with financial responsibility for the account) agrees to be fully responsible for total payment of treatment performed in this office.

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I fully understand and agree to all terms in this office policy.

Names of patients that are the responsibility of the signer (Please Print):_____

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_____ Date_____
Signature of patient(or if minor, person responsible)