Richland Creek Family Dentistry Office Policies

We are grateful you've given us the opportunity to assist you with your dental needs. As an office we would love to provide you with the best dental care in a timely and professional manner. Please read and initial the policies below. If you have any questions regarding the below policies, please do not hesitate to ask our staff.

Financial Policy: I understand that payments are expected when services are rendered. Cash, Visa, Mastercard, Discover, American Express, Care Credit, Lending Club and Checks are accepted forms of payment. If insurance is being filed any deductible or co-pay is also due at time of service. I understand that even when given an estimate of what insurance may cover, any balance that insurance does not cover is my responsibility.

Initial: _________ Date: ________

Cancellation Policy: If you are unable to keep your appointment, a 24-hour notice is required. This gives our staff adequate time to fill that appointment slot. There will be a $30 charge for any appointment missed or canceled without a 24-hour notice. Initial: _________ Date: ________

Late Policy: I understand that if I am 15 mins late or more to my appointment I may have to be rescheduled due to time. If you believe you will be there 15 mins late, please call ahead so we can adjust the schedule accordingly. Initial: __________ Date: _______

Insurance Policy: As a courtesy to our patients, we will file insurance claims for primary insurance only. Any secondary insurance must be filed by the patient. I authorize the release of all information needed to file any insurance claim. I authorize the release of all information to my insurance company and assign all insurance benefits to Richland Creek Family Dentistry. Initial: _________ Date: ________

Default Policy: If you do not make payments on your account within 90 days of services or refuse to pay your account balance, you will be sent to collections. In the event of default, you will be responsible for all costs incurred in collecting your balance. Initial: ________ Date: _______

Minors: If your child is under the age of 18 a guardian must be present, or a signed letter must be sent with the child giving permission for any treatment to be performed. Initial: _________ Date: _________

I have read and understand all the above policies

Signature: ________________________________ Date: ________________