Rivergate DENTAL

Office and Payment Policy
PLEASE READ CAREFULLY AND SIGN BELOW

We would like to welcome you and your family to our office. We are very pleased you have chosen our office for your dental needs. Please take a few moments to familiarize yourself with our payment policy. If you have any questions please feel free to ask.

As with any other business, Rivergate Dental expects payment when services are rendered. Accepted forms of payment include MasterCard, Visa, American Express, Care Credit, personal checks and cash. Financing is also available. A $25.00 charge will be added to all returned checks. Should you not be in the position to make full payment today, communicate this with the receptionist as soon as possible. We appreciate the opportunity to service your dental needs and will do our best to make arrangements that will be agreeable for both parties.

Rivergate Dental extends the courtesy of filing insurance on behalf of the patient. Dental insurance is filed only when proper dental information is provided and has been verified. You will be responsible for any amount, not covered by your dental insurance. This includes any co-payments and deductibles as indicated by your insurance carrier. If the patient is covered by more than one insurance company, we will accept the primary insurance. Secondary insurance will be filed for reimbursement to the patient only. If your primary insurance has not paid within 45 days after the filing, you will be asked to pay the account in full at that time. We feel this is a reasonable amount of time and any correspondence to your insurance company after this point is your responsibility.

It is extremely important that you make all dental appointments scheduled. We reserve this time especially for you and will call you the day before to confirm your appointment. Please give a minimum of 24 hours notice for any appointment that you will not be able to make. A $25.00 fee may be assigned to your account for failure to show at a scheduled appointment without prior notification.

Please read and sign below:

I have read the above information and understand that I am financially responsible for this account. I understand that I will be responsible for any balance unpaid after the 45 days from the date of service. I also understand that is it my responsibility for settling this account and that a statement may be sent to me indicating any balance due. I also agree to pay any court costs or collection fees incurred in the attempt to collect the amount owed should it become necessary. Interest will accrue at 18% per annum after 45 days.

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Patient Date