TENNESSEE RIVER
DENTAL

Financial Policy

THANK YOU FOR CHOOSING US AS YOUR DENTAL PROVIDER! We are committed to your treatment being successful. Please understand that payment of your incurred fees is a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- All patients must complete our Patient Information Forms before seeing the Doctor.
- Payment is due at the time of service.
- We accept cash, checks, VISA, MasterCard, American Express, or Discover.
- A charge of $39.00 will be assessed for any returned checks.
- Extended payment plans are available to qualifying individuals through 3rd party services.

Regarding insurance:
We view your dental benefits as an entity that financially assists you with your dental care and finances. Your dental benefits are based on a contract between your employer and the dental benefits company. Any deductible or estimated co-payment amount will be due at the time of treatment. As a courtesy we will be glad to file your claim for you if you bring 1) your dental benefits wallet card and 2) all required employer information. You will be expected to pay for services at the time they are rendered. If the office is unable to verify your dental benefits information before treatment, you will be expected to make full payment for services rendered. Once we verify dental benefits status we will, as a courtesy, file the claim on your behalf. In the unfortunate event that your benefits company does not pay, the balance is your responsibility. If payment for services rendered has not been received from your dental benefits company, within 45 days, the remaining balance for treatment is considered due and collectible from you.

I authorize the release of any information or x-rays necessary to process insurance claims.

Adult Patients:
All patients are responsible for payment at time of service unless prior financial arrangements have been completed.

Minor Patients:
The adult accompanying the minor and the parent-guardian are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA, MasterCard, American Express, Discover, or payment by cash/check at the time of service has been verified.

Missed appointments:
We reserve the right to charge and collect fees for broken appointments – (appointments that are cancelled or broken without 48-hours advance notice.) Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Service Charges:
I understand that a service charge of 1.5% per month will be added to any unpaid balance due over 30 days.

Financial Responsibility:
In the event of nonpayment of charges for services rendered, I agree to pay all the costs of collection including a reasonable attorney's fee, court costs, or collection costs and hereby wave all rights of exemption under the Constitution of the State in which I reside. I understand the attorney's fee awarded by the court will be based on all spent on the case, until the debt is paid in full.

I have read this contract and understand its provisions.

_____ _____
Signature of Patient or Responsible Party Date Signed

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Signature of Parent/Guardian