RTP COSMETIC & FAMILY DENTISTRY

Our Financial Policy

Please understand that payment of your bill is considered a part of your treatment.
The following is a statement of our Financial Policy, which we request you read and sign.
FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH OR VISA/MC. NO PERSONAL CHECKS WILL BE ACCEPTED.
WE OFFER CARECREDIT, AN AFFORDABLE FINANCING OPTION FOR TREATMENT.

Regarding insurance:

Our practice participates with a variety of insurances that is in the PPO network. If you have any questions whether or not our practice participates with your particular plan, check with your insurance company. If your plan is one with which we participate, we will bill and collect according to your plan. All deductibles, co-payments and disallowed charges will be due at the time of service.
We will do all that we can to get the most benefits possible reimbursed for you, however we cannot bill your carrier for your reimbursement unless you provide us with current insurance information. You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of usual and customary fees. If insurance has not responded to a claim within 60 days of submittal, the full account balance becomes the account holder's responsibility.

Regarding Missed Appointments:

We do not "double book" appointments. When we schedule an appointment, the time is reserved just for you. If you must change an appointment, please give us at least 24 hour's notice. There is a fee of $75 for missed appointments or for appointments that are canceled without a 24 hour's notice. In some cases, we reserve the right to charge the full value of the missed time. Please help us serve you better by keeping scheduled appointments. **REMINDER**: We do require a 10% deposit for any appointments scheduled for extensive work.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns. **In order to accept assignment of benefits, we now require that a credit/debit card be left on file with our office.**
I authorize RTP Cosmetic & Family Dentistry to keep my signature on file and to charge my credit/debit card account for:

- ☐ Balance of charges not paid by Insurance within 60 days and not to exceed $50.00. We will call on all balances over $50.00 for authorization before charging your credit card.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to RTP Family & Cosmetic Dentistry and provide alternative payment for committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient Name	Best Contact Number
Cardholder Name	Billing Address
Account Number	City, State, Zip
Expiration Date: V-Code:	Card Type

Signature of Responsible Party:_____ Date_____