FINANCIAL POLICY OF RIDGE DENTAL

The following statement of our Financial Policy requires each patient to read and sign prior to any treatment.

INSURANCE

Please be advised, ***your dental insurance is a contract between you and your insurance company, to which our office is not a party.*** Ridge Dental agrees to **file** your claim for you as a **courtesy.** ***Should there be any denial of payment by your insurance company, you are responsible for your balance and are aware you must contact your insurance company and/or human resource department to correct any issues that may arise with your insurance contract.*** Failure to submit payment for services rendered will result in collection action!

Our office accepts assignment of insurance benefits. Co-Payments and deductibles are due **at the time treatment is rendered**. Our office can not bill your insurance company without current insurance information.
Any services not fully covered by your insurance, becomes YOUR responsibility.

All balances not paid within thirty (30) days after service (unless insurance payments are pending) are subject to a 1.5% per month late fee.

BILL PAYMENT

Please understand that payment of your bill is considered part of your treatment. ***Full payment is due at the time of service, unless there is an assignment of insurance benefits. Our office accepts cash, personal checks (with proper Identification), Visa, MasterCard, and Discover.***

If we are forced to take collection or legal action, for any unpaid balances, you agree to pay interest, collection fees, and any reasonable attorney or court costs incurred by our office in connection with said action.

MINOR PATIENTS

A minor must be accompanied by an adult to receive dental treatment in our office. All charges incurred by a minor are the responsibility of the adult accompanying the minor unless a parent or guardian has been established in our system for this minor. All unaccompanied minors will be **DENIED** treatment unless it is an EMERGENCY; in this case an approval from the minor's doctor must be presented prior to the EMERGENCY care.

_____
PATIENT'S NAME- Printed

_____ _____
SIGNATURE ***of person responsible for account*** DATE