# RICHMOND DENTAL FINANCIAL POLICY

Thank you for choosing Richmond Dental as your dental care provider. The following is a statement of our Financial Policy which we ask you to read and sign prior to your first appointment with us.

**Insurance**

As a courtesy to you, our office will accept assignment of benefits from your insurance company as long as we have a valid credit card on file. If your insurance breaks down the difference while you are in the office, you may pay the difference by Visa, M/C or Debit. If your insurance does not break down the difference, we will use the credit card on file to collect the balance once we have received the insurance payment. You will only be notified by phone if the balance is in excess of $250.00.
**If the credit card on file is declined three times for the portion owed to our clinic, your account will be reverted to Non-Assignment and you will be required to pay for your visits up front.**
Any claim not paid by your insurance company within 30 days, will be automatically put through your credit card, and a receipt for this transaction will be mailed to you. It will be your responsibility to be aware of your dental coverage, please be aware that some, and perhaps all of the services provided may not be covered. **(Initial ____)**

**CARDHOLDER INFORMATION**

**Credit Card number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
**Expiry Date on card:** ___/___

X_____
**Cardholder Signature**

**Returned Cheques**

There will be a $35.00 NSF fee on all returned cheques. **(Initial ____)**

**Missed Appointments**

Unless cancelled at least 48 hours in advance, our policy is to charge for a missed appointment or a short notice cancellation at the rate of $50.00 per hour. Please help us to serve you better by keeping scheduled appointments as this time is reserved for you. **(Initial ____)**

**Pre-Determination Policies**

Many insurance companies require authorization for specific procedures in advance. In most cases, we can begin treatment before receiving an authorization however; patients need to understand that in the event the insurance company refuses to pay for treatment, you are responsible for all fees. Naturally, we always provide you with the full fees in advance so that you know the exact cost of treatment. **(Initial ____)**

**Financing**

Financing options are available and can be discussed for major treatment as well as Invisalign cases. **(Initial ____)**

I have read the Financial Policy, and I understand and agree to this Financial Policy.

X _____ Date: _____
**Signature of Patient or Responsible Party**