Financial and Payment Policy

Thank you for choosing us as your dental care provider. We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our payment and financial policy.

We offer the following methods of payment:

- Payment in full is due at the time of service. Cash, Check, Debit Card, MasterCard, Visa, Discover and American Express accepted. (There is a $25.00 fee for all returned checks.)

- For patients with insurance, we will accept payment directly from the insurance company, but require that the deductible and non-covered fees be paid at each visit.

- We collaborate with Care Credit for a financing option. Applications can be completed online at www.carecredit.com or in office with the assistance of our receptionists. If approved, print off approval with our account number and bring to your appointment.

- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for child's co–payment.

- Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.

- Not all dental services are a covered benefit in all contracts. It is your responsibility to know your benefits.

- You (not the insurance company) are responsible to us for all our fees for services rendered to you.

- An ESTIMATE will be given of the benefits that the insurance company is expected to pay. Remember that this is only an ESTIMATE and that the actual cost may vary.

- BROKEN/MISSED APPOINTMENT: Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for you convenience and hold great value. We require 24-hour notice of canceling or rescheduling your appointment, if 24 hours' notice is not given a $50.00 fee will be charged.

I acknowledge I have received and agreed to North Rivers Dental Practice's Payment & Financial Policies.

Patient or Responsible Party: _____

Date: _____ Relationship to Patient: _____