

RidgePointe Dental Financial and Office Policies

Welcome and thank you for choosing RidgePointe Dental for your dental care needs. We are committed to providing you with the highest quality of care, in an efficient and timely manner. We hope that providing you with our policies in advance, we can prevent any misunderstandings or frustrations at the time of your visit. If you have any questions regarding these procedures please ask any one of our staff members at anytime.

Initial: _____ **Insurance:** Your insurance policy is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract. All charges are your responsibility whether your insurance company pays or not. We also may do services that are not covered under your plan, we do not base your treatment on what your insurance plan allows. We do our best to get benefits from your insurance company; however it is **YOUR** responsibility to ultimately know your policy. When making an appointment with one of the doctors or hygienist, it is your responsibility to confirm with our office and your insurance company that the practice is **currently** under contract with your plan. A copy of your up-to-date insurance card is needed at all times. **If you do not provide the correct insurance information at time of service, and we bill the wrong insurance company we can not bill the new insurance company for that date of service.** As a service to you we will bill most insurance companies. However our policy is that they have 60 days to acknowledge and send payment for your claim. Sometimes insurance companies say they send us a request asking for more information that is not always true. If you receive a letter from the insurance company please call our office to let us know and make sure we received the copy so that if we didn't we can send it be for the 60 days is up. At 30 days you will receive a letter stating that we have not heard from the insurance company, **if you receive this letter it is your responsibility to follow up on this.** If it goes past the 60 days and we have not heard from your insurance company, you will receive a letter with the copy of the claim so that you can submit the claim yourself and the balance will be your responsibility. We do not file to secondary insurance companies. Our policy is that when we get the claim back from your primary we will send you a copy of the claim and any information you need to submit the claim. You will have to send a copy of your Explanation of Benefits from your primary that you receive from the insurance company.

Initials: _____ **Treatment plans:** If the doctors find that you need treatment, we will do our best to help find a payment plan to fit your needs. After the doctor makes his diagnosis, he will bring the chart and you up to the front to work with one of the financial coordinators. The financial coordinator will type up a treatment plan and go over the cost of treatment and your estimated portion. Remember this in only an estimate. If we are not in network with your insurance the price will change because we do not know what your allowed amount is. We do offer a variety of payment options. For your convenience we do take cash, check, MasterCard, Visa, Discover, and American Express. We also do offer CareCredit which we can help you apply here in the office. If you have to come back for more than one visit we do offer a ½ now and ½ when you come back. Or we also offer a three month plan here in the office for those with balances that qualify. We will ask you to sign the bottom of the treatment plan, saying that you understand your portion and options available financially, by signing the bottom it doesn't mean you agree to do the treatment only that you are aware of what is recommended.

Initials: _____ **Check-in:** We do our best to keep on schedule, so please arrive for your appointment on time so that other patients are not inconvenienced. We need to be notified of any insurance changes prior to your appointment to ensure your appointment stays on schedule.

Initials: _____ **Check out:** Please be prepared to pay any past balances on your account and any new balances, unless prior arrangements have been set up. Any procedures that require a case being sent to a lab requires that at least half is put down. If you can not follow that policy, please make arrangement before your appointment with one of our financial coordinators.

Initial: _____ **Minors:** A parent or guardian **MUST** accompany a minor for all visits to our office. The parent(s) or guardian(s) are responsible for providing current insurance information for the minor and or payment in full for services provided. As long as the minor is covered under the insurance they will be under that account. **Once the patient is 18 you do have the option to have them move to their own account. We will need a letter from both the old responsible party and the person being moved to their own account stating that it is acceptable to separate the accounts. Starting from that point on the new responsible party will be responsible for all charges. We can not make someone responsible for their own account with out their knowledge. We will not automatically move a patient from one account to another.**

I have read, understand, and agree to the above office and financial policies. Any questions I had were answered and I understand my responsibilities and do agree to comply with them. I do hereby authorize this dental practice to release to my insurance company any information, including but not limited to diagnosis and record of treatment or examination which were rendered to me. I also authorize payment of benefits directly to this practice for any services rendered. I do understand that I am financially responsible for all charges and that this does not release me from the responsibility of making sure that payment is made in a timely manner. I also understand that this is my responsibility to settle any dispute regarding what benefits are due from the insurance company. I also understand that if I allow this account to become delinquent that may be turned over to a collection agency. If this should occur, I will be responsible for any collection fees in addition to the original amount due. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release on information necessary for insurance filing and pre-certification by signing this statement.

Responsible party for account: (print) _____

Responsible party for account: (sign) _____

Date: _____

List of anyone on your account that you are Responsible party for:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____