River City Dentistry, PC (Jason Allred, DMD)

rivercitydentistry.com
rivercityoffice@gmail.com
737 N.Thornton St. Suite #A • Post Falls, ID 83854
(208)777-8668

RIVER CITY DENTISRY
Family and Cosmetic Dentistry

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

POLICIES

DENTAL INSURANCE

We submit claims to all dental insurances as a courtesy to our patients. If you supply us with your dental plan handbook, we will try to determine your benefits. Any information relayed to us by your insurance carrier is not a guarantee of payment. Quoted portions are an ESTIMATE ONLY.

Most insurance companies have their own fee schedules, and benefit percentages are pased upon those fees. Those fees may differ from the fees of River City Dentistry. All restorations (fillings) are done with a resin-based composite material. Some insurance companies will only pay at the amalgam (silver) rate for restoration of posterior (back) teeth. The patient is responsible for the total amount not covered by insurance. It is your responsibility to know your plan limitations, such as waiting periods and maximums.

FINANCIAL POLICY

Your estimated portion is due at the time of service. We accept Cash, Check, Visa and Mastercard. We also have CareCredit financing available. A finance charge of 12% per year or 1.6% per month will be charged on ALL delinquent accounts over 90 days, and all accounts over 120 days are turned over to collections. There is a $20 fee for all returned checks. Please discuss any further financial concerns you might have with us.

MISSED APPOINTMENTS

Time has been set aside especially for each patient when they schedule an appointment. We require a 24 hours notice of cancellation. Please be aware that you will be charged $50.00 for the appointment if 24 hours notice of cancellation is not received or if you don't show up.

After three occurances of late cancellations and/or no-shows within one year, we hold to right to dismiss patients from the office.

CONSENT FOR SERVICES

1. The undersigned hereby authorized doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of the patient's medical need, and to be used for instructional purposes as necessary.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the above named patient. I understand that using anesthetic agents embodies a certain, risk. Futhermore, I authorize and consent that doctor employ such assistance as deemed fit to provide recommended treatment.
3. PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.
4. To avoid any misunderstandings regarding your dental insurance, we wish our patients to know ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT AND THAT PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.
5. We are happy to file the forms necessary to see that you receive the full benefits of your coverage: however, we cannot guarantee estimated coverage. If for some reason your insurance company has not paid their portion within sixty days from the start of treatment, you are responsible for payment at that time.

Signature _____ **Date** _____

This will become a part of your permanent file. If you would like a copy, please ask.

Response Date: _____