Financial Agreement:

Thank you for choosing us as your dental hygiene care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: house calls, dental fees, booking fees, late charges, and any other services not directly provided by the dental hygienist(s).

FEE AGREEMENT
All fees are based on the Current Dental Terminology (CDT) provided by the American Dental Association (ADA).

1) New Patient Appointments: Include a $50 house call (CDT CODE: D9410), dental case management $50 (CDT CODE: D9997), $30 assessment of patient (CDT CODE: 0191).

The patient assessment determines the type of dental cleaning required. Dental cleanings range from $90 to $480. The patient will be quoted and given a treatment plan to schedule accordingly.

2) Recare appointments: Recare appointments depends on the patient's level of dental hygiene care needs. The patient will be quoted and given a treatment plan to schedule accordingly.

3) After the new patient appointment: All appointments thereafter are subject to a $40 scheduling fee. The scheduling fee covers travel for the dental hygienist, bookkeeping, record charting, and instrumentation handling.

Dependent on the patient's level of comfort, it may take the hygienist a few appointments before performing a dental cleaning. It is common to have a scheduling fee more than once a month to build an honest and safe rapport with the patient.

Our services are specialized and space is limited. The scheduling fee is non-refundable if the appointment is canceled in less than 48 hours, unless special circumstances.

INSURANCE
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of our insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service,

it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT

FULL PAYMENT is due at the time of service unless billing to Medicaid insurance. We accept credit cards (Visa, MasterCard, Discover) or ACH payments (checking or saving accounts). A preferred payment method will be saved on file for the patient. All payments are secured and stored using Quickbooks.

Any overdraft fees RDH Communications inherits from the patient's account from ACH payments will be the patient's responsibility.

Unpaid balances over 20 days old will be subject to a daily interest charge of 1.5% up to 60 days. After 60 days from when the balance is due, charges will be disputed. If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

The parties agree that in the event of a dispute over any payment or fee due to RDH Communications LLC by the undersigned, the Circuit Court of the specific county shall have exclusive jurisdiction and venue for any litigation filed by either party.

By signing this agreement, I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Legal Guardian Signature and/or patient signature

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Date ____