*At River Street Dental we believe that it is important not only to provide the highest quality dental care, but to make dental care affordable for our patients. Please ask us any questions you may have-we are glad to be of assistanc*e.

RIVER STREET

DENTAL

**Payment Options and Billing Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Payment In Full (Day of Treatment):** | | | 5% courtesy discount if paid by check or cash |
| **Multiple Appointment Payments:** | | | Some procedures require multiple appointments. When this happens we will ask for ½ down with the remainder due at your last appointment. The above discounts will still apply. |
| **No or Low Interest Payment Plans:** | | | We offer the Care Credit healthcare credit card. Visit their website or call us for details of payment options through Care Credit. [www.CareCredit.com](http://www.CareCredit.com) |
| **If Statements are Sent:** | | | I realize I will pay finance charges, late charges and/or collection fees if my statement is not paid by the due date. |
|  | | |  |
| **Billing Information:** | **If We Have a Billing Question May We Leave a Message? YES NO**  **May We Discuss Your Dental and Billing Information with a Family Member(s)? YES NO**  If yes, please provide the following information for family member(s):  Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Dental Insurance:** | | We are happy to process insurance claims as a service to you at no additional charge. As we are not a party to the agreement between you and your insurance carrier, we are not responsible for how much or when they pay your claim. We will provide to you an estimate of fees. You are responsible for all fees in their entirety. Our fees are not based upon any insurance schedules, and may be above insurance allowances. | |
| **Dental Insurance:**  ***Please Present Dental Card*** | | **Insurance Information:**  Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s SS# \_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Insured: \_\_\_Self \_\_\_Spouse \_\_\_Child \_\_\_Other | |
| *(Insurance cannot be processed properly if all information is not filled out)* | | **Other Insurance Information:**  Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s SS# \_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Insured: \_\_\_Self \_\_\_Spouse \_\_\_Child \_\_\_Other | |
| *I authorize River Street Dental to release to my insurance carrier any information needed to determine benefits payable to the related services. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits to River Street Dental. I understand that I am financially responsible for all services rendered and if my insurance hasn’t paid within 60 days, I am responsible for all services rendered. I further understand that if my benefit administrator requires that payment for claims goes to me that I will be responsible for all charges and I will assist in coordinating my benefits if I have more than one policy.*  **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

***Consent and Acknowledgement of the above information is in place until revoked in writing.***