

Rivergate Dental Care Office Policy

Welcome to Rivergate Dental Care. Please read and sign the following stating that you understand our office policy.

Payment is expected at the time of service.

I elect to pay: Cash____, Check____, Master/Visa/American Express/Discover____, CareCredit_____.

For those desiring monthly payments, we have made arrangements with CareCredit to do just that. For your convenience, you may pay as little as 3% of your total bill, or you can pay your bill in full with no interest penalties. There is no annual fee for CareCredit. If you desire to arrange for CareCredit billing we will provide you with an application form and process it for you.

If you have dental insurance:

You will be required to pay any out of pocket expense at each visit. Dental insurance was not designed to pay for ALL dental care. All levels of payment by insurance companies, including allowed fees, usual and customary fees, are governed by the premiums that you pay. They have nothing to do with the actual charges. When we verify your coverage over the telephone with your insurance is only an ESTIMATE of your actual out of pocket expense. We will not know exactly what the insurance will pay until we receive payment on the claim. Most questions regarding coverage should be addressed to your employer or your insurance company.

If treatment is for your child or a minor:

In the case of single parent custody, separation of parents, or legal guardianship by another family member or friend, the person who signs this payment policy will be held ultimately responsible for payment of this account. If Parent(s) do have legal guardianship, but child is taken care of by a family member or friend, we will require a consent for treatment from the legal guardian before treatment more than an exam, x-rays, and cleaning be performed.

If you cannot keep a scheduled appointment, we ask as a courtesy that we be given 24 hour notice of cancellation otherwise a \$50 cancellation fee will be added to your account.

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with the office of David A. Weaver DMD, P.C., that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement [including associates] shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as this section.

I have read the above, I understand the payment policy and agree that I am responsible for any charges incurred regardless of insurance coverage. I also agree to be held responsible for any attorney or collection fees incurred for collection of an overdue account.

Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above.

Signature:_____ Date: ___/___/___