

# **River Park Dental Financial Policy**

Thank you for choosing River Park Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible and so we offer several payment options.

Please be aware of the following:

- **River Park Dental requires payment at the time of your treatment.**
- **We accept cash, check, Visa, MasterCard, American Express, or Discover Card**
- **CareCredit offers no interest\*, convenient low monthly payment plans.\*\* We can assist your application process for CareCredit.**
- **We offer a 5% courtesy discount to patients who pay for their treatment with cash or check at the time it is scheduled.**
- **For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.\*\*\* It is your responsibility to provide correct insurance information. Ultimately, the patient is responsible for the payment of fees for dental services rendered regardless of what insurance will or will not cover.**
- **A fee of \$50.00 is charged for patients who miss or cancel an appointment with less than a 24 hour notice.**
- **River Park Dental charges \$20.00 for returned checks.**
- **In the event of non-payment, patient is responsible to pay all interest that accrues on all past-due amounts at the rate of 21% per annum (1.75% per month) until paid in full. In the event any amounts are referred to a third party debt collection agency, the patient will also pay any other amount allowed for by law (such as interest, court costs, attorney's fees, etc.), and the patient will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah Code Annotated, sec.12-1-11. The above terms apply to all amounts incurred by patient or for any individual for whom patient has legal responsibility.**

If you have any questions, please do not hesitate to ask.

***I, the undersigned, agree to the aforementioned terms of River Park Dental's financial policy.***

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Patient Name (please print) \_\_\_\_\_

\*If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

\*\*Subject to credit approval

\*\*\*However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.