RIVERPLACE
PERIODONTICS

Patient Financial Responsibility

Cash or Non-Insured Patients

- Your first visit/initial examination is a charge of $145-$200 and is due in full at the time of the service. Treatment appointments will be collected a week to 10 days before appointment.

Understanding Your Insurance Coverage

- You are responsible for understanding the details of your insurance coverage.
- It is not possible for us to know all the details of your policy.
- Your insurance is a contract between your employer and your insurance carrier.
- Not all services are covered by insurance, only those contracted with your employer.
- Each patient's insurance policy is different.

Predetermination of Dental Benefits

As a courtesy, we will submit a predetermination to your insurance company. This will enable us to estimate what they will pay and what they will expect you to pay for the services and treatment you receive.

Once submitted, a Predetermination of Benefits will be mailed to our office and to the patient. This process with insurance can take 2-10 weeks. If you are scheduled prior to the receipt of your predetermination of benefits, payment for services will be due in full and any payment made by insurance will be refunded. ***Please note, refunds can take up to 30 days once requested.***

Processing Claims (a request for insurance payment) for Services Rendered

If you would like us to submit claims on your behalf, please:

- Provide a copy of your current insurance card(s).
- Complete and submit the Patient Information form.
- Alert our office of any changes in your insurance coverage.

Out-of-network Insurance

We are out of network with most insurance plans. There are some that we may find it necessary to collect in full and have the insurance company make reimbursement to you directly.

Authorization

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

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Signature of Patient, Parent, or Guardian Date