OFFICE AND FINANCIAL POLICY

--PLEASE READ AND SIGN THE FOLLOWING OFFICE AND FINANCIAL POLICIES--

MINOR CHILD: It is required that the legal guardian accompany their minor child (**Age 17 and under)** to each appointment, unless we have a consent form for each family member and payment arrangements have been taken care of prior to the appointment. The adult accompanying the child must also bring a copy of the child's insurance card if applicable.

REQUIRED PAPERWORK: Registration forms and health histories are updated every 12 months. We also ask to see your insurance card at check-in to ensure that we have your most current coverage on file. ***Healthcare laws dictate that verify identity by asking for a Photo I.D.*.** If there is more than one family member in the practice, paperwork must be completed for each individual.

PAYMENT IS DUE AT TIME OF VISIT: *Your insurance policy is a contract between you and your insurance company.* We are **NOT** a party in that contract. We make every effort to help estimate insurance benefits, and file claims with the insurance company for you.

PAST DUE ACCOUNTS: Balance due on all accounts past 60 days may be charged an interest rate of 1% per month. Also, if your account is sent to collections for untimely payment, you may be charged a reasonable collection charge as well as attorney fees and costs.

RETURNED CHECKS: There is a $25.00 fee for checks returned due to insufficient funds. We require immediate payment, in cash or money order, upon notification of insufficient funds. Rhoades Family Dentistry, PA may pursue bad checks within the boundaries of the **"BAD CHECK LAWS"** in the State of Kansas in accordance with K.S.A. 21-3707. **We are happy to offer MasterCard, Visa, Discover, and Care Credit as payment options.**

MISSED APPOINTMENTS: Any appointment that is not kept or is cancelled with less than 24 hours notice will be considered a "failed" appointment. We strive to be punctual, and the appointment is reserved for you or your child. For this reason, failed appointments may be charged a fee of $50. The fee will be charged directly to the person who is responsible for the account. A third "failed" appointment may be regarded as termination of relationship, and/or dismissal from the practice.

FOR OUR PATIENTS WHO ARE MOVING: Please allow 1 week for requested record transfers. A release form will be requested to be completed and signed by the patient or guardian of the patient. **A $20 per person payment is required for supplies, labor, and time. We are more than happy to email records to a provider at no cost.**

Consent is hereby given to perform any and all examinations, tests, procedures and treatments necessary and/or advisable. I authorize **RHOADES FAMILY DENTISTRY** to file insurance and direct payment for services to the provider of treatment. I also authorize **RHOADES FAMILY DENTISTRY** to release information, to include medical/billing information, to referred specialists, insurance company or guarantor of this account.

I UNDERSTAND I AM TO BE FINANCIALLY RESPONSIBLE FOR ANY BALANCE REMAINING ON THIS ACCOUNT FOR SERVICES NOT COVERED BY INSURANCE.

I hereby acknowledge by my signature, that I have read, and understand and agree to the terms of this document.

_____	_____/_____/_____	
Patient's Name	**Patient's Date of Birth**	
_____	_____	_____
Patient, Parent or Guardian's Signature	**Relationship to Patient**	**Today's Date**