

Rhea-diant Dental
Dan Fields III, DDS
180 Walnut Grove Road
Dayton, TN 37321

FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. Our office is dedicated to providing optimal care for every patient in the most economical way possible. The following is a statement of our financial policy. Please read it and let us know if you have any questions. We feel misunderstandings can be avoided when complete information is exchanged.

OPTIONS FOR PAYMENT OF TREATMENT:

1. Non-Insurance Patients:
Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience we accept cash, personal checks, money orders, MasterCard, Visa, and Discover. We can also help you make arrangements with Care Credit for interest free financing.
2. Insurance Policy:
 - a. We will file an insurance claim on your behalf as a courtesy to you, however, you must supply, prior to treatment, all the necessary information for filing.
 - b. Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of treatment.
 - c. It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
 - d. If your insurance company has not paid their liability in full in 60 days, the balance then becomes the patient's liability.
 - e. For patients whose insurance company pays them directly, payment is expected on the date of treatment.
 - f. Your insurance policy is a contract between you and your insurance company and the financial responsibility for your treatment is yours whether the insurance company pays or not.
3. Finance charges of 1.5% per month will be applied to balances over 60 days old.
4. Long term payments can be arranged. We will be happy to talk with you about the details.

Please feel free to ask any questions you may have regarding this policy. We are most willing to help you in any way that we can.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO ITS TERM.

X _____
Signature of Patient/Responsible Party

DATE: _____

I allow for the release of my x-rays and records to my insurance company as needed for proper processing and payment of my dental claims. I allow for release of my x-rays and records to other dental and medical specialists, as needed, for my dental care. I also allow for photographs to be taken of my mouth and dental work as a record of progress of my treatment.

X _____
Signature of Patient/Responsible Party

DATE: _____