SOUTH RIVER DENTISTRY

INSURANCE & FINANCIAL POLICY STATEMENT

I understand that the charges of this account remain the responsibility of the person signing this form, either: The **Patient, Guarantor, Parent, Guardian or Accompanying Adult.**

- As a service to you and/or your family, our office, South River Dentistry, a division of CVDC, will bill your insurance carrier solely as a courtesy to you. You are responsible for your **estimated** portion and any deductibles on the day services are rendered. If your insurance carrier does not remit payment, the balance will be due in full from you.
- If for any reason the insurance company does not pay, I (the undersigned) assume full responsibility of the unpaid charges. If the insurance company does not pay benefits within 60 days from our filing date, the guarantor will become responsible for the outstanding balance. Please remember that insurance is not a guarantee of payment and is not to be considered as a total method of payment for our services.
- Prices, fees or benefits quoted in our office are **ESTIMATES** only. Final charges or benefits paid by the insurance company will be based on work performed and claims filed after work has been completed.

If any payment is made directly to you for services billed by us, your recognized obligation is to send the same promptly to Jeff T. Blackburn, DDS or Sarah Kennealy, DDS at South River Dentistry.

I understand that if a check I have written for dental is returned by the bank for non-sufficient funds there will be a returned check fee of $35.00

Initials __________

I understand that unpaid balances may be subject to a monthly finance charge of one and one-half (1 & ½) percent per month.

Initials __________

(PLEASE COMPLETE THE BACK OF THIS FORM)

If this account becomes past due and is assigned to an attorney or collection agent, South River Dentistry, A division of CVDC is entitled to attorney's fees of 1/3 of the unpaid balance and costs.

- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to South River Dentistry, a division of CVDC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
- In the event that services that I receive are as a result of an accident or other occurrence for which a third party may be responsible, I understand that South River Dentistry will not hold my account pending from the third party. I also herby grant an irrevocable lien to South River Dentistry, a division of CVDC on any proceeds I may recover in a settlement or verdict against the third party and instruct my attorney to remit payment in full to South River Dentistry, a division of CVDC including any accrued interest costs or attorney's fees.

We offer several options for payment: Cash, Check, Visa, MasterCard, American Express, Discover & Care Credit. For details, it would be our pleasure to assist you.

I fully agree to the financial responsibilities and assignment of insurance benefits as stated above.

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Patient Signature **Date**

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Parent/Guardian/Responsible Party **Date**

We appreciate your trust and welcome you to our practice!