Thomas R. Rheuben, D.M.D., L.L.C.

Financial Responsibility Policy

Our Financial Responsibility Policy is a necessary part of assuring the financial resources needed to maintain quality dental services for our patients. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Our fees are meant to be reasonable and competitive; we will be happy to discuss them with you. Please don't hesitate to ask about the cost of a service **before** it is performed.

We request full payment at the time of service if insurance does not cover your visit. If we are billing your insurance carrier, you will be expected to pay your deductible and/or estimated co-payment. We accept VISA, MasterCard and American Express for your convenience.

INSURANCE: We will, as a courtesy to you, bill your insurance. This is done with the understanding that you remain totally responsible for your charges regardless of your insurance coverage. We will look to you for full payment if your insurance has not paid within 60 days of service We do not have control over your insurance company's interpretation of their responsibility to pay your bill, our agreement is with you.

APPOINTMENT POLICY: We require 24 hours notice for any schedule changes. If adequate notice is not given, you will be charged $50.00 per 1/2 hour scheduled. After two missed appointments, without notice, we will no longer schedule you.

I personally guarantee & accept responsibility for all charges incurred by me or my dependents--regardless of any insurance coverage I may or may not have.

Accounts over 90 days old are subject to 1.75% per month finance charge (21%A.P.R.). Accounts referred to a collection agency will be subject to all collection and attorney fees. There is a $25.00 fee for all returned checks.

That's the end of the unpleasant stuff! We appreciate the opportunity to serve your needs.

SIGNATURE ______________________________________ DATE__________________
(This signature indicates that you have read and understand our Financial Responsibility Policy).