DANIEL J. RIES DMD PC
FINANCIAL POLICY FOR THE OFFICE

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend out time and energy toward that end.

* All accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with our Office Manager. We accept cash, checks, CareCredit, Discover,Visa,Mastercard and American Express. There will be a 10% cash courtesy for patients without insurance with payment in full at time of service. An extra 5% courtesy discount is extended to senior citizens who pay in full on the day of service. For Visa, Mastercard and Discover card, there is a 5% courtesy given as we pay a credit card user fee.

- On accounts which have established arrangements, the payment is due upon receipt of the monthly statement. Any balance outstanding more than 90 days will bear interest at 18% per annum or 1.5% per month.

- Insurance is gladly billed as a courtesy to our patients, when you provide us with current information and any necessary forms. Even though you may have insurance pending, you will receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 90 days or for negotiating a disputed claim. Insurance reimbursement is a contract between you, your employer and the insurance carrier. YOU are responsible for payment of your account.

- There will be a $25 minimum charge for any broken or missed appointment not cancelled or rescheduled with a 24 HOUR NOTICE. The length of time scheduled for you determines the charge. We will not reschedule any patient after two missed appointments. Our time must be used efficiently as possible to keep our expenses down at a minimum and our fees within reasonable limits.

- A $25 fee will be charged for dishonored checks.

I HAVE READ THIS CREDIT POLICY AND UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I UNDERSTAND THAT DELINQUENT ACCOUNTS MAY BE ASSIGNED TO A CREDIT REPORTING COLLECTION SERVICE. IF IT BECOMES NECESSARY TO EFFECT COLLECTIONS OF ANY AMOUNT OWED ON THIS OR SUBSEQUENT VISITS, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES. THIS WILL ENSURE THAT OUR RESPONSIBLE PATIENTS WILL NOT BE PENALIZED TO COVER COSTS INCURRED BY THOSE WHO DO NOT PAY ON TIME.

Signature:_____ Date:_____