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Columbia Basin PEDIATRIC DENTISTRY

Rusty J. Walker, DDS
Craig D. Ritchie, DDS, MSD
J. Brent Gill, DDS, MS

Orchard Hills PEDIATRIC DENTISTRY

705 Gage Blvd, Ste 300
Richland, WA 99352
(509) 375-5000
Fax: (509) 783-7576

PATIENT FINANCIAL POLICY

Thank you for choosing Columbia Basin Pediatric Dentistry. We are committed to providing you with the best possible pediatric dental care.

The accompanying parent/guardian is responsible for the cost of services, payable in full, the same day of service unless insured. Our office files insurance claims as a courtesy to you. If you do not receive payment notifications within 30 days from your insurance company, you should call your insurance company to ensure that the claim is being properly and promptly processed.

Co-payment for services is required at the time that services are rendered for insured patients. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, please understand the following:

1. You authorize the release of information to all of your insurance carriers with the understanding that Dr. Walker, Dr. Ritchie, and Dr. Gill's office does not accept responsibility for collection of your insurance claim. *Insurance reimbursement, coverage, and benefits are a contract between you, your insurance carrier, and your employer.*

2. You are responsible for the entire fee regardless of any insurance claim, determination, maximum, or limitations on benefits, including our customary fee not paid by your insurance company.

3. All accounts 60 days past due are subject to a service charge of 18%, with a minimum of $1.00 charge per month. Accounts 90 days past due, regardless of delinquent insurance claims, will be sent to our collection agency.

4. You will receive a statement each month for the outstanding balance of your account, even though you may have an insurance claim pending.

If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for all professional services rendered. I have read all of the information on this sheet and have completed the patient information form. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my dental insurance.

_____ _____

Signature Date