Riversbend

Beauty and Excellence in Dentistry

Appointment Policy

Our staff at Riversbend Dental is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability and material preparation at specific times during our work day. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. Please be advised of the following requirements:

- We require 48 hours' notice for cancellation of a scheduled appointment
- A cancellation fee of $40.00 will be added for all missed or cancelled appointments with less than 48 hours' notice. Appointments longer than 60 minutes will result in a higher fee
- If there are three missed or cancelled appointments without 48 hours' notice appointments in a year time frame, we reserve the right to not schedule any further appointments or to require a deposit in order to schedule a future appointment.
- Family emergencies will be taken into consideration

_____ _____

Signature of patient (or responsible party) Date

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Financial Policy

Your co-payment is due at the time services are rendered. Riversbend Dental offers the following payment options:

- Cash, Credit (all major credit cards accepted), Care Credit, Money Order and Checks (A $35.00 charge will be added to the account for any NSF check returns)
- On qualified balances we may offer a Three (3) month payment plan. In order to qualify for this option, a credit card would need to be placed on file to be charged each month.
- Office Policy is to charge 1.5% monthly fee with the minimum $2.00 to all accounts that are over 60 days past due.
- We do our best to minimize the use of outside sources to aid in the collection of delinquent balances. Any account 60 days past due may be sent to a collections office after all efforts by Riversbend Dental have been exhausted. The minimum fee charged for your account being sent to collections is $50.00

Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patient's financial capabilities.

Financial Consent

The patient (or person with financial responsibility for the account) agrees to be fully responsible for total payment of treatment performed in this office.

I fully understand and agree to all terms in this office policy.

Names of patients that are responsibility of the signer (please print):

_____

_____

_____ _____

Signature of patient (or if minor, person responsible) Date

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1995 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have the right to read the *Notice of Privacy Practices* before deciding whether to sign this Consent.

This office reserves the right to change the privacy practices as described in the *Notice of Privacy Practices*. If it is changed, a revised *Notice of Privacy Practices* will be issued.

I have the right to request that you place additional restrictions on the use or disclosure of my health information. You are not required to agree to these additional restrictions, but if you do, you will abide by our agreement (except in an emergency).

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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Insurance

Riversbend Dental is committed to helping our patients maximize their benefits. As you may be aware, medical and dental insurance are becoming increasingly complex. We are always available to answer your questions, however, your insurance policy is a contract between you and your insurance company.

As a medical provider, we are not party to that agreement. The patient portion (co-payment) of your bill must be paid at the time of service. We ask our patients to provide us with complete dental insurance information. As a service to our patients we will bill insurance companies for services and allow 45 days to render payment in full. After 60 days, you are responsible for the entire balance which is due in full upon request.

Insurance policies vary considerably; therefore we estimate your coverage in good faith but cannot guarantee coverage or payment amounts by your insurance company. Riversbend Dental can only provide estimates and not exact amounts.

If you have any questions please do not hesitate to contact our office at 513.494.0333 or email office@riversbenddental.com

We look forward to seeing you!

You're Riversbend Dental Team.

Brandon W. Romick, D.M.D. & Associates

Record Release Request

Date:_____

Previous Dental Office: _____

Address: _____

City: _____ State/Zip: _____

Phone: _____ / Fax: _____

I request and authorize the release of dental records and x-rays relevant to dental treatment, or copies of such, and request they be transferred to: office@riversbenddental.com, if unable to transfer records via email please mail to the address below.

Patient's Name: _____

Date of Birth: _____

Signature: _____

If patient is a minor, relationship to patient: _____

6270 River's Bend Drive Maineville, Ohio 45039