Riley Family & Cosmetic Dentistry Financial Policy

We accept the following methods of payment:

Payment can be made via:
Cash, Visa, Master card, Discover, American Express
Extended payment plans: Care Credit (Please ask for details)

Regarding Financial Arrangements:

Payment for services rendered is considered part of your treatment or your child's treatment and is due at the time of service, unless financial arrangements are made prior to treatment.
Patients with outstanding balances after insurance has processed claim will be billed. Full payment is expected and if the patient has any questions regarding the bill, the staff at Riley Family Dentistry will be glad to try and answer them or you should receive a remit from your insurance company, if any questions you may call your insurance to see why they processed charges the way they did.
Patients are reminded that Alabama law does not allow writing worthless checks. However accidents happen and at Riley Family Dentistry we understand that and allow the patient to correct any such mistake, Patients will incur a $35.00 charge for each return check.
We do not hold accounts over 90 days, any account balance over 90 days will be subject to being sent to the attorney's office or the Credit bureau, and patient will be responsible for all legal fees.

Regarding Insurance:

Riley Family Dentistry is a participating provider for Several Dental insurance's. If you are not sure if your insurance is on the list hanging in lobby, please ask.
If you like, we will be happy to assist you in filing your insurance. This is a special service we provide for our patients to help eliminate some of the often confusing paperwork associated with processing claim forms. Please remember your insurance policy is a contract between you and your insurance company. Our office is not a party to the contract. We will do our best to estimate your portion of the fee and help you utilize your insurance benefits. However, you will be responsible for any amount unpaid by your insurance company.
Please be aware that some treatments provided may not be considered customary by your insurance carrier and may be labeled "non-covered" or "plan exclusion" under your particular plan according to each individuals policy. Through the years our office has learned the level of coverage of any dental plan is directly related to the level of payment made to the plan by the policy holder's employer.
The patient is expected to pay his/her estimated share of the bill at each visit. Understanding this is ONLY estimate by the % your insurance policy states it covers, all insurance policies are different, it is a courtesy for us to file your insurance, and the patients responsibility to know there coverage. After claims have been processed patient will be responsible to pay any outstanding balance.

Regarding Scheduled Appointments:

We respect your time,therefore we do not "double-book" appointments. **When you schedule an appointment with us, that time is reserved exclusively for you.** Any change in this appointment affects many people. If you are unable to keep your appointment, please give us as much notice as possible, preferably 48 hours, so that we may offer this time to another patient. There is a charge of $40.00 not covered by your insurance.
For all Monday appointments must give us notice the Thursday prior, due to office is closed on Fridays.

Please let us know if you have questions. We reserve the right to modify these policies at any time without further notice

Acknowledgement of Notice of Privacy Practices - I have had a copy of this office's notice of Privacy Practices made available to me to read. I also understand that I can request to receive a copy of this notice for my records at any time.

Consent for Services

I consent to the performing of dental procedures deemed to me or my child to be necessary by the doctor. To the best of my knowledge this paperwork has been accurately answered. I will bring all future changes in my or my child's medical history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to our health. Minor children must be accompanied by a parent or legal guardian to all appointments, unless discussed in advance with our office.
I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension of the proposed procedure or a change from what was previously noted. If that occurs, I authorize the doctor and staff to perform such procedures as necessary and desirable in the exercise of professional judgement and I will be responsible for any associated fees. I authorize my insurance benefit to be paid directly to Dr. Riley's office. I understand and agree to the above conditions of treatment, the Notice of Privacy Practices, and the office Financial Policies and will be responsible for payment for my treatment.

Signature: _____Date:_____

For Office Use Only - We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____Other (Please Specify):_____