WELCOME TO REFLECTION RIDGE DENTAL

Before we begin with your dental work at Reflection Ridge Dental ("RRD"), an explanation of the recommended treatment and an estimate of the fees involved will be provided for you. It is important that you remember that treatment plans can change due to unforeseen circumstances.

The cost of dental care is changing rapidly. It is the interest of both of us to keep these costs to a minimum. **You are responsible to pay at least the estimated patient portion at the time of your appointment or have financial arrangements completed with RRD.**

The following payment arrangements are available:

1. Cash or check
2. Major Credit Cards*
3. In office financing. As a courtesy to our patients, we offer financing on most treatment plans. This is done by having a credit card or debit card placed on file. We will charge that card an agreed upon amount every month. The date that the charge occurs every month is also flexible to best fit your financial needs. Please ask one of our treatment coordinators about this program if you have any questions.
4. Care Credit. They offer a zero percent credit card for medical treatment. An application is available through our office. The application can occur over the phone, via the internet or by mail. If you are approved by Care Credit and pay the balance off in the allotted period there will be no interest expense to you. The entire process takes a few minutes and there is no cost to apply.

*Upon presentment of your credit card, you hereby authorize RRD to charge your credit card for RRD's applicable fees at the time of your appointment. You will also be responsible for any other invoiced charges related to your appointment. The invoiced amount will be due and payable immediately upon receipt. Any invoiced amounts not paid within ninety (90) days from the invoice date will accrue interest at the lesser of eighteen percent (18%) per annum or the highest interest rate permitted by Kansas law.

In the event you fail to pay any amount owed to RRD within sixty (60) days from RRD's invoice date ("Delinquent Amount") and you have a credit card on file at RRD, you hereby authorize RRD to charge your credit card for the Delinquent Amount in accordance with the terms of this paragraph. Prior to charging your credit card for the Delinquent Amount, RRD will provide you with at least ten (10) days' prior written notice setting forth the Delinquent Amount and that date the credit card will be charged. Following receipt of the written notice, you may cancel the authorization for such credit card charges by providing RRD with at least three (3) days' written notice prior to the date the credit card will be charged by RRD. You understand that this authorization will remain in effect until you cancel it in writing upon not less than three (3) days' prior written notice. If the above noted payment dates fall on a weekend or holiday, you understand that the payments may be executed on the next business day. You hereby certify that you are the owner and an authorized user of this credit card account and will not dispute the above transactions with your credit card company; provided the transactions correspond to the terms indicated in this paragraph.

We will still process your claims with insurance if applicable. Any overpayments on your account due to insurance payments will be refunded to you when all insurance payments have been received

for your dental health care

The Responsible Party named below and/or the Patient agrees to pay our costs for collecting amounts owing, including court cost, attorneys' fee, collection agency fees, and collection cost. The cost of collection will not include costs that were incurred by an employee of Reflection Ridge Dental. The final fee for collections will not be in excess of fifteen-percent (15%) of the unpaid debt after default.

I have read and understand the above options for payment of my treatment. I understand that I am responsible for the entire fee for myself and anyone I place on my account with Reflection Ridge Dental regardless of any insurance coverage.

Signature: _____ Date: _____

Printed Name:_____ Ins Card:_____

Address: _____ Drivers License # _____

City, State and Zip Code_____

Debit or Credit Card #_____
Expiration Date _____
CCV Code _____