Dr. Charles Ruefenacht, DDS

Innovative Dental Solutions

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing our office to manage your dental care needs. We are honored by your choice and are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, regardless of the presence of dental insurance benefits.

Patient Financial Responsibilities

- The patient (or patient's parent or guardian, if a minor) is ultimately responsible for the payment for treatment and care in our office.
- We are pleased to assist you by billing your contracted insurer. However, the patient is required to provide us with the most current, correct insurance information and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service (unless otherwise arranged with our treatment coordinator) and for your convenience, we accept cash, check, and most major credit card at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of our office. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charges for missed appointments without **2 business days, not including weekends and holidays.**
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize **Dr. Charles Ruefenacht, DDS** and his staff to release my dental information acquired in the course of my examination and/or treatment to the necessary insurance companies to obtain payment on my behalf and/or other physicians required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to **Dr. Charles Ruefenacht, DDS** for any services rendered covered by my insurance. I understand that I am financially responsible for any charges not covered by my insurance.
- By my signature below, I authorize **Dr. Charles Ruefenacht, DDS** or his staff to communicate by mail, voicemail, and/or email according to the information I have provided in my patient registration information.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

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Patient Name (printed)

_____ _____

Signature of Patient or Guardian Date