River City Dentistry Insurance Agreement

I understand and agree that dental insurance policies are an arrangement between my insurance carrier and me. I understand that AS A COURTESY TO ME, River City Dentistry, will prepare the necessary forms to assist me in making collections from the insurance company. It is my responsibility to notify the dentist of any changes in my insurance. I authorize my insurance company to pay River City Dentistry, directly. Claims are filed the day of service and will be refiled once. Failure to receive payment after the second filing will then be the insured's responsibility to call the insurance company. However, I understand and agree that all charges for services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services will be immediately due and payable. I agree to pay all costs, expenses and collections fees, including, but not limited to reasonable attorney's fees of 33%. All accounts will be charged $35.00 for any returned checks.

It is our intention to provide you and your family the best dental care. We appreciate the opportunity to treat you and your family.

*Signature*____

*Date*____