



***Central Virginia Dental Care***

*(Trading as River City Dentistry)*

***Financial Agreement***

*I understand and agree that dental insurance policies are a contract between my insurance carrier and me. I understand that AS A COURTESY TO ME, River City Dentistry, a division of Central Virginia Dental Care PLC, will prepare the necessary claim forms to assist me in gaining payment for dental services from my 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, a division of Central Virginia Dental Care PLC, directly. Claims are filed the day of service and will be re-filed once. Pursuit of payment after the second claim filing with my insurance company will be my responsibility. 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 collection fees of 33% of the amount referred to a collection agency or an attorney for collection and monthly finance charges of 1.5%. All accounts will be charged \$50 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 \_\_\_\_\_