Kaitilin K. Riley D.D.S. INC
336 12th Street
Paso Robles, Ca. 93446

Thank you for choosing us for your dental care. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our information form before seeing the doctor.

Patient is responsible for all charges. Payment is due at time services are Rendered. We accept cash, checks, Visa, MasterCard or Lending Club.

If you have dental insurance, we will help you receive your maximum allowable benefit. However, you must understand the following:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

2. We will be happy to submit your dental insurance claim for you on a reimbursement basis. Payment is expected the day services are rendered. The insurance claim will also be submitted that day. The insurance check will go directly to you.

3. Some insurance companies will limit payments, indicating that our charges are in excess of their "usual and customary" allowable benefit for a particular service. We would like you to know that our fees are generally considered to fall within the acceptable range of our community. Please note that you are responsible for all charges your insurance company does not pay.

4. All services may not be a covered benefit of your insurance contract. Some insurance companies arbitrarily select certain services they will not cover. You will be responsible for all charges that are not covered benefits.

You are responsible for all charges made to your account. There will be a $20.00 fee charged to you on all returned checks. Balances over 30 days will be subject to a 1 1/2% finance charge. Please let us know if you have any questions regarding the above information. We are here to help you.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and responsible attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits and/or filing of formal complaints to the insurance commissioner on my behalf. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature_____ Date_____