Riverfront Dentistry
Office Policy
Anthony Elgohary, D.M.D

WELCOME – The benefits of healthy smile are immeasurable! Our goal is to help you reach and maintain maximum dental health, by providing the best treatment possible in a gentle, caring environment. Please read and sign our office policy below and fill out all forms completely. Should you have any questions, please ask. The better we communicate, the better we can care for you.

PAYMENT POLICY – Payment is due at the time of treatment. We accept cash, check, Visa/Mastercard, Discover and Care Credit. For extensive procedures we offer partial payment in stages, as the treatment progresses, which will be set forth in a separate contract. Our Financial Coordinator is available by appointment to discuss these financial options. Interest shall accrue on any balance that is due over 30 days at a rate of 1.5% per month until paid. Should the undersigned default under these terms, and this account is referred to an attorney/collections agency for collections, then the undersigned promises and agrees to pay all cost incurred by said attorney/collection agency. There will be a $30 handling fee for any returned checks.

PATIENTS WITH INSURANCE – As a courtesy to our patients, we will file your insurance claims for you. Claims will be submitted promptly. At the time of treatment your will be responsible for paying in full any deductibles, **estimated** co-payment(s) or any other balance not paid by your insurance company. For patients who do not have the assignment of benefit insurance option(some Anthem BC/BS policies), you will be responsible for the **entire** amount at the time of service, since the insurance company will be paying you **directly** and not our office.

If payment is not received from the insurance company within 30 days after submitting the claim, the patient/responsible party shall be responsible for any remaining balance and hereby agrees to pay in full upon demand. If payment in full is not received within 30 days of the date demand is made, the patient/responsible party agree to pay interest on the balance due at the rate of 1.5% per month until paid, and further agree to pay all collection cost incurred.

APPOINTMENTS – **Your appointments are reserved times specifically for you**. Out of courtesy to Dr. Elgohary, our staff and other patients, ALL appointments must be cancelled or rescheduled at least two business days in advance. A fee of $50.00 per half-hour appointment time may be charged for all appointments cancelled/rescheduled without at least 48 hour notice.

PARENTS & LEGAL GUARDIANS – Dr. Elgohary may need to discuss treatment options, medications, etc. with you as your child's appointment progresses. It is our policy that parents and or/legal guardians remain in the office during dental procedures on minors (children under 18 years). Your cooperation will help to ensure a successful and informative visit for you and your child.

AUTHORIZATION, CONSENT – I hereby authorize this office to release any information, concerning my treatment and diagnosis to my insurance company or other health care practitioners being consulted. I hereby authorize and request the performance of dental services for my child or myself. I also give my consent to any advisable and necessary dental procedures, x-rays, medications or anesthetics to be administered by the attending dentist or staff.

I have read and understand the above policy:

_____ _____ _____ _____
Signature of Patient/Responsible party Date Signature of Doctor's Representative Date

_____ _____ _____ _____
Signature of Patient/Responsible party Date Signature of Doctor's Representative Date

Patients with Insurance: I, herby authorize the office of Anthony Elgohary, D.M.D., P.L.L.C. to affix my name to any and all dental claims or documents as related to any and all dental health benefits due me and my dependents. I hereby authorize payment of benefits otherwise payable to me, directly to the office of Anthony Elgohary, D.M.D., P.L.L.C. This "Signature on File" and "Assignments of Benefits" will be valid from this date and shall expire in five years, A photocopy of this document may act as an original.
Some BC/BS policies do not have the Assignment of Benefits option and patient will have to pay the full amount at the treatment visit.

TODAY'S DATE_____ PATIENT SIGNATURE_____DR. REPRESENTATIVE_____