Ridgeview Dental
Candi Filbrandt, D.D.S.
18130 Wright Street
Omaha, NE 68130
(402) 884-8880

Payment and Insurance

It is our policy to receive payment as treatment progresses. If you have any questions concerning our fees or methods of payment, please let the clinic know. A written cost estimate of treatment needed can be given to you before the service is provided on any restorative work. This is only an approximation of coverage. As a courtesy, the clinic completes the universal insurance forms at our expense.

Dr. Filbrandt believes in providing dental services that are suited to achieving optimal oral health for you and your family. With the numerous insurance carriers and policies available, it is impossible to be familiar with the specific treatments covered and the coverage amounts for each. Since you are receiving professional services, you are ultimately responsible for payment whether or not it is a covered item by your insurance.

Insurance coverage rarely pays 100% for any dental procedure. In addition, Ridgeview Dental is a preferred provider for specific insurance policies only. If you have any questions about your specific coverage, please refer these questions to your insurance carrier or to your employer. *Please keep in mind that the final cost may be less or it may be more, and you alone are responsible for any remaining balance.*

For all patients, we request your estimated patient portion and deductible be paid on the day of service. You are responsible for any balance not paid by your insurance carrier, in full within thirty days. If you seek financial assistance, this must be set up prior to this date. I understand that I will be charged at a rate of a minimum of $2.00 per month or a 1.3% per month on balances over 30 days and I am liable for all legal and collection fees.

For patients that personally receive their insurance payments, full payment is expected at time of dental services. The clinic requests that a copy of you EOB (explanation of benefits) be sent to our office.

Please check below the option (s) most convenient for you, to pay for your dental treatment, in full, today.

___ Cash or check (returned check fee is $30)

___ VISA/MC Account #____ Exp _______

___ AMEX/Discover Account #___________________________________ Exp _______

___ Care Credit (see receptionist for application)

For your protection, Ridgeview Dental requires a valid form of photo identification to be placed on file.

I authorize the dental office of Dr. Candi Filbrandt to process payment from time to time as the dental office deems necessary, to settle my account in full, with verbal permission first.

Signature____ Date_________________
Responsible Party/Patient/Guardian (if patient is a minor)