DENTAL ON 45
34484 N. US HIGHWAY 45, SUITE C
THIRD LAKE, IL 60030

PATIENT FINANCIAL POLICIES AND PRACTICE GUIDELINES

We want to thank you for selecting our practice for your dental needs. Please review each of the guidelines outlined below. We require that you or your financial guarantor **initial** next to each guideline and **sign** the bottom of this document.

Patient (s) Name(s): _____

_____ **Information**: You agree to provide your correct name, current and correct address, cellular or other phone number, email address, insurance information, social security number, driver's license or picture identification at the time of registration or as requested by the practice at any time.

_____ **Financial Responsibility**: You accept financial responsibility for all fees for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the child assumes liability. Minors are not allowed without a parent or guardian, unless accompanied by an adult, with a letter giving permission to treat patient.

_____ **Payment Methods**: We accept cash, check, Visa, Master Card, Discover, and Care Credit.

_____ **Patients with Insurance Coverage Co-Payments and Deductibles**: All co-payments, deductibles, non-covered services are to be paid at time services are rendered, according to our office policy. Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. You accept full responsibility for all expenses even if your insurance company is billed as a courtesy.

_____ **Patients without Insurance Coverage:** The fee for the treatment rendered must be paid in full on the day service is rendered.

_____ **Appointments**: Our office values your time, please value ours. There is a 24 hour cancellation policy for a Tuesday through Friday appointment, 48 hour notice for a Saturday appointment and Friday cancel for a Monday appointment. A fee of $25 will be charged for a cancelled same day appointment or a non-cancelled and missed appointment. A fee of $50 will be charged for the second consecutive cancelled same day or missed appointment. A third consecutive missed appointment will require you to pre-pay for your dental treatment, in order to reschedule the appointment. If the third appointment is failed or cancelled short a fee of $100 will be charged and patient dismissed from our practice. Your appointment time is exclusively for you. Please be considerate.

_____ **Copies of x-rays**: The x-rays can be sent via e-mail to a dentist or patient's email at patient's request with no charge to patient.

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_____ **Slow Insurance Response**: We will try to collect from your insurance company, after 90 days we shall consider your services, your financial responsibility and it will be your responsibility to seek reimbursement from your insurance. There are instances where insurance responds a lot faster to the patient.

_____ **Statement Policy**: Our office sends patient statements each month. Payments are due upon receipt of statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services rendered. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees.

_____ **Collection and bank fees**: Accounts over 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a **minimum** charge of $35.

_____ **Patient Discharge**: Dental on 45, reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document.

_____ **Insurance Claims**: Our office will submit insurance claims. You authorize direct payment of dental benefits to Dental on 45. In the event your insurance company sends payment for a claim for services to you (the patient), you agree to endorse the payment to our practice.

I have read and understand the terms of the policy. I have initialed and signed, that I completely understand each item and agree to the terms above.

_____ _____

Patient Signature (Parent or Guardian, if minor) **Date**