Financial Policy

Welcome! Our goal is to provide you and your family with optimal dental care. We want you to feel as comfortable as possible throughout our relationship. This includes understanding your treatment plan as well as our financial policy. **Financial arrangements are both necessary and beneficial to maintain a sound professional relationship.**

Financial Agreement:
Patients are expected to pay for services at the time they are rendered. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. We offer payment plans through Care Credit. By arrangements with Care Credit we can offer patients upon approval, an interest-free term loan (Up to 6 months) with no down payment, no annual fee and no prepayment penalty.

Patients with Insurance:
Our patients that have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. As a courtesy to you, we will process all your insurance claims electronically, and **benefits are expected to be paid within 30 days**. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become "self-pay". You are responsible for any amount your insurance company chooses not to pay. We encourage you to call your insurance company to expedite payment to us.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Amount due that is not paid in full within 30 days will be charged a finance rate of **1.5% per month. Returned checks will be subjected to a minimum fee of $40.00.**

Delinquent balances on your account over 90 days old will be referred to our attorneys and will be reported to all three major a credit bureaus. In the event that your account should become delinquent, you may be responsible for any attorney fees and court cost incurred in an attempt to collect on your account. Venue will be in Kane County, IL.

Appointments:
It is vital that you give our office a 24 –hour notice to avoid charges (equivalent to an office visit of $75.00). **Please understand that when you schedule with us, we have reserved this time just for you.**

Please indicate your understanding and acceptance of these financial policies by signing below.
It is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient's name (please print) **Date**

Patient's Signature

Financial Coordinator (Witness)