Oak Brook Dental Center

PRACTICE POLICY

Thank you for choosing us as your dental care provider. 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 Practice Policy which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information Form before seeing the doctor.

Payment Policy

FULL PAYMENT IS DUE AT TIME OF SERVICE; UNLESS OTHER SIGNED ARRANGEMENTS HAVE BEEN MADE.

WE ACCEPT CASH, CHECK, OR VISA/MASTER CARD/DISCOVER CARD/AMEX.

WE OFFER PAYMENT PLANS ON MAJOR TREATMENT, INCLUDING 3RD PARTY FINANCING.

Regarding Insurance

We may accept assignment of insurance benefits once we confirm eligibility. However, we do require patient portion of the fees to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services.

Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

All minor patients must be accompanied by a parent or guardian. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Missed Appointments

Unless canceled at least 48 hours in advance, our policy is to charge $50.00 per appointment hour for missed appointments. Please help us serve you better by keeping scheduled appointments. Numerous missed appointments may require credit card guarantee prior to rescheduling.

* Please note a $25.00 returned check fee will be charged for returned checks.

Thank you for understanding our Practice Policy. Please let us know if you have questions or concerns. I have read the Practice Policy. I understand and agree to this Practice Policy:

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party