FINANCIAL POLICY ACKNOWLEDGEMENT

The following information is to inform you of our financial policy. If, at any time, you have any questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check VISA, MasterCard, Discover and American Express. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options. Check policy: If your check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $50.

We will communicate all recommended treatment options and associated fees, prior to start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask to make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep you scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of $100. Should you find it necessary to reschedule an appointment, please provide u with a notice of two business days (48 hours) to avoid being charged a missed appointment fee.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time of treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

Important Facts about your Dental Insurance

- Dental Insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have (i.e., Traditional, PPO, or DMO), and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered.

Patient/Guardian Signature: _____ **Date:** _____

P: (773) 525-7725
2454 N. ASHLAND AVE. | CHICAGO, IL 60614

Sweet TOOTH DENTISTRY

Forms of Payment of Balances Due

In order to facilitate to access to very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks, Care Credit or Compassion Dental.

I understand that if I become delinquent in my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect this account.

After your dental insurance has paid for dental services rendered at Sweet Tooth Doc, Ltd, you may have an outstanding balance. This balance may include any deductibles, co-payments, denials, and non-covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization.

Credit Card: (check one) ____Visa ____MasterCard ____Discover ____Amex ____Care Credit ____Compassion

Card #: _____Expiration Date:_____

Card Holder Signature: _____

Billing Address: _____State_____ Zip_____

I certify that I have read, fully understand, and accept the above financial policy.

Signature: _____ **Date:** _____

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