WINNETKA DENTAL ARTS

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to initial each section and sign prior to any treatment.

_____ PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, personal checks, Mastercard, Discover, American Express and Visa. When insurance applies, we will collect any deductible and estimated co-payment at this time.

_____ INSURANCE

- As a courtesy to you, we will provide you with a statement of services and charges for you to submit to your insurance company. Please contact your insurance company for details of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid.
- All charges you incur are your responsibility, regardless of your insurance coverage.
- Your insurance company will make payment directly to you. We do not accept assignment of benefits.
- We do not bill medical insurance for services rendered at our clinic.

_____ COLLECTION FEES

Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred.

_____ MINORS

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.
Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service.
Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

_____ MISSED APPOINTMENTS AND CANCELLATIONS

In order to provide the best services for our patients, we require at least 48-hour notice for cancellations or for rescheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $50 fee per hour of scheduled time will be charged for missed and short notice (less than 48 hours). Multiple failed appointments may result in being dismissed from the dental practice.

_____ CONSENT

I have read, understand, and agree to the above terms and conditions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

_____ COMMUNICATION

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Signature_____ Date_____