

# Aesthetic & Reconstructive Dental Associates

## OFFICE GUIDELINES

### CONSENT

I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I understand that I will be given the opportunity to discuss my treatment plan with the doctor and that financial arrangements, if necessary, will be agreed upon before treatment is started.

If care is being rendered on a minor, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for the payment.

### FINANCIAL RESPONSIBILITY

1. Balances remaining beyond (30) days from first bill will accrue interest at a rate of 1.5% per month (18% annual rate) unless other financial arrangements have been made.
2. There is a charge for all returned checks. This charge will be in the amount of the maximum allowed by the Illinois state statute.
3. Personal credit may be checked.
4. In the event of default I promise to pay legal interest on the indebtedness, collection costs, and related attorney's fees.

**Patient initials** \_\_\_\_\_

### DENTAL INSURANCE

We are happy to submit insurance claims on your behalf, however, we cannot guarantee any estimated coverage from your insurance company. Unless prior arrangements are made, you will be expected to pay your portion as services are provided. **You are responsible for any remaining balance on your account after the insurance company has made payment.** Because your insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over a claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits. Any balances not paid by the insurance company within 60 days of submission become the patient's responsibility.

### CANCELLATION POLICY

If you are unable to keep an appointment, please provide no less than 2 business days notice prior to your scheduled appointment. Out of respect for appointment availability for other patients, and to continue to accept discounted insurance plans, a **\$60.00 broken appointment fee per half hour of scheduled time** will be assessed for a failed appointment.

**Patient initials** \_\_\_\_\_

### PAYMENT OPTIONS

Cash, check or credit cards: For your convenience, we have made arrangements to accept payment by several major credit card companies. **If treatment is started without any financial arrangement I understand that I am to pay for the treatment in full at the time service is rendered.**

Please review the following options and *chose* the payment plan you prefer:

\_\_\_\_ For patients who desire a monthly payment plan, we can arrange **up to** 12 months of interest free financing. Please inquire about an application at the front desk.

\_\_\_\_ You may prefer to pay for treatment at each appointment and if multiple appointments are required you may divide half of your payment at the start of treatment and the balance upon completion.

I understand and agree to the financial policy of this office and that my signature will authorize assignment of insurance benefits to this office.

--	--

Patient's Signature

Date