Jeffrey D. Staley-Henne, D.M.D.
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(217) 463-4155

Thank you for choosing us for your Dental treatment. 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 Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Patient History and Financial Policy forms before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, or Visa/MasterCard, and Discover. We offer financing options with prior credit approval.

We may accept assignment of insurance benefits after your first visit. We do require all co-pays (usually 20-50%) and deductibles be paid at the time of service. (The balance is your responsibility regardless of your insurance plan's fee schedule or co-pays.)

We cannot bill your insurance company unless you give us your insurance information with a completed claim form and/or insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. However, as a courtesy, we will assist you in receiving all the benefits that are due regarding your treatment with our office. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you for payment.

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Two or more missed appointments will be grounds for terminating your treatment with our office. Please help us serve you better by keeping your scheduled appointments.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand and agree that I am responsible for payment for these services. In the event that I fail to pay in a timely manner, I understand and agree that I may be held responsible for all collection costs, including reasonable attorney fees.

Signature of Patient (Parent/Guardian if Minor) Date