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Patient/Parent name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dependents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dependents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dependents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT TREATMENT AND FINANCIAL POLICY**

*Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime 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, and sign prior to any treatment.**

**Please note:** Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and CareCredit.

**Please note:** Additional fees will be applied for returned checks. All account balances over 30 days are subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for all collections costs including attorney fees, court costs, or collection service fees associated with the recovery of the monies due on the account. Costs of a collection service, in the amount of 30% of the account balance, will be added if collection occurs.

***Do you have insurance?***

* As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
* **All charges you incur are your responsibility, regardless of your insurance coverage**. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
* 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.
* We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child’s) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
* We ask that your pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, or CareCredit at the time we provide the service to you.
* Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within **60 days** or your claim is denied, you will be responsible for paying the **full amount** of the claim at that time.
* We will cooperate fully with regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
* **You may wish to complain to your company’s benefit representative should your benefits be less than expected.**

**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 (s) and Cancellations:** Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment. A charge may be assessed for multiple missed, short notice, or cancelled appointments. 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 authorize my insurance company to pay my dental benefits to my dental office. 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. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care, to third party payers and/or health practitioners.

**Communications with you:** 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.

**Patient/Parent name (printed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Parent signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_