River Forest Dental Studio PC

7700 W MADISON STREET | RIVER FOREST IL, 60305 | (708) 366-6760

Written Financial Policy

Thank you for choosing River Forest Dental Studio PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their complete treatment plan with cash or check at the time of service.

-For patients with Insurance—We will provide the service, at no charge, of billing your insurance company for services provided by our office. Full fees not covered or patient's portions or co-pays are the out of pocket responsibility of the patient and are due at the time of service.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

River Forest Dental Studio PC requires payment for procedures at the time of the appointment.

For patients with dental insurance, we can submit for you, at no charge, if time permits, a pre-treatment estimate for needed procedures so patients know their out of pocket responsibility.

For treatments requiring multiple appointments, we accept payment in thirds, if the total amount due is over $1000.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $75 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

River Forest Dental Studio PC charges $50 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

[1]Subject to credit approval

For HIPPA Privacy Practices

Please read or acknowledge that you have been offered the opportunity to read the *Notice of Privacy Practice* sheet attached to the clipboard. Then, please sign below. (You may refuse to sign this portion)

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Patient Signature (or Parent if minor) Date

(amended 3/24/2014)