

HINSDALE DENTAL FINANCIAL POLICY

Thank you for choosing Hinsdale Dental as your dental provider. 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.

REGARDING INSURANCE

As a service to our patients, we will bill most insurance companies. While providing these services for our patients, it is extremely difficult for us, and our Doctors, to be aware of the multitude of individual coverage for each of these plans. Each plan has its own stipulations regarding the coverage and payment for dental services. Within the same insurance company, plans may differ depending upon the specific contract you or your employer may have with your insurance carrier. It is each patients responsibility to know the details of their individual plan.

It is our policy to bill you for our services at the time we bill the insurance company. When we receive an insurance payment, it will be reflected on your account. You are then responsible for the balance. If your insurance company has not paid the account in full within 60 days, the balance will immediately become your responsibility. Please be aware that some and perhaps all of the requested services provided may be non-covered services. Cosmetic work such as bleaching, veneers and some crown work are considered cosmetic and payment is required in full at time of service, unless other arrangements have been made. Please speak with our account manager for payment options on large treatment plans.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS

USUAL AND CUSTOMARY

Our practice is committed to providing the best treatment for our patients, our standards are high and our fees are fair. We charge what is usual and customary for our area. You are responsible for difference regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

If you need to cancel an appointment, we ask that you do so at least 24 hours in advance so that we can make the appointment available to another patient. Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

X _____
Signature of Patient or Responsible Party

Date _____