

SIMPLY DENTAL

341 E. Geneva Road, Carol Stream, IL 60188
630/588-0003 phone 630/588-0005 fax

OUR FINANCIAL POLICY

Thank you for choosing Simply Dental for your health care needs. We are committed to providing the very best Dental care treatment. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Our Financial Policy applies to all service rendered by our office staff.

Practice payment policy:

1. Patients/guardians are financially responsible for all charges, regardless of third party involvement.
2. Full payment is due at time of services, unless prior insurance billing arrangements have been made IN WRITING.
3. Patients with insurance will be required to pay all 'out of pocket' fees at time of service.
4. Any coverage or payment dispute is a matter between the insurance policyholder and the participating insurance company.
5. We accept: Cash, Check, and the following credit cards - Visa / Master Card / Discover and American Express. We participate in CareCredit assistance.

Patient/guardian financial responsibility includes the following:

You have a responsibility to provide accurate and complete information about your mailing address, Dental Insurance, secondary Dental Insurance coverage, and other billing information. If any information changes - name, address, phone, insurance coverage, etc. - you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior to services being rendered.

Patients with Private Insurance/Medicare Coverage: Our Dentist's participate with the Medicare Program, and with most major insurance companies. We will file claim(s) to your insurance for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans in which we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient payment agreement: I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, copayment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 75 days, the outstanding services will become my responsibility.

Patient/Responsibility Party/Guardian Signature

Date