

FAMILY DENTAL CENTER
2640 GOLF ROAD SUITE 125
GLENVIEW, IL 60025
847-998-1281

OFFICE FINANCIAL POLICY

Our office is committed to providing quality care for all of our patients. We charge what is usual and customary for our area.

Payment Options

We accept VISA, MASTERCARD, and cash as forms of payment. Interest free financing is also available to those who qualify. Personal checks are only accepted from long established patients.

If you have dental benefits, please provide us with your insurance card. We will do our best prior to your first appointment to have accurate information regarding your policy. As a courtesy, we file primary and secondary claims for our clients. Please note you will be asked for your estimated portion at each visit. Should you need to see our Non Participating Specialist, we will require payment in full.

Missed Appointments

If you are unable to keep a scheduled appointment, we request that you inform us 24 hours before the scheduled appointment time. This allows us to give that valuable time to another individual. We reserve the right to charge a cancellation fee of \$125.00 with any notice less than 24 hours.

Your signature below confirms that you read, understood and agree to this financial policy. I understand that if collection action should become necessary for recovery of any monies due under this contract, I agree to pay any and all collection costs of up to 40%, court costs, and reasonable attorney fees.

Signature of Patient/ Responsible Party

Date

ACKNOWLEDGEMENT FORM FOR THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been shown a copy of the Family Dental Center's Notice of Privacy Practices and may request a copy at any time.

Printed Name _____

Signature _____ Date _____

The Family Dental Center routinely leaves appointment reminder messages on patients' answering machines. Do you accept this? YES NO

If no, please complete the following:
This is the other method of communication I prefer: _____

OFFICE USE ONLY

The office was unable to obtain a signed Acknowledgement form from the patient for the following reasons: