## Financial Policy

Welcome to Perfect Smiles of Palos Park! Thank you for selecting our office for your dental care. We are committed to providing excellent dental care with concern for your personal needs. The following information will acquaint you with our office financial policies and allow us to provide a high quality of service to you.

- **INSURANCE BENEFITS**: We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payment level that is quoted nor have information on benefits used in any other dental professional's office if used within the plan year. Any balances remaining after your insurance pays, are due with 15 days of billing.
- **PAYMENT**: Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patient CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. A service charge of 1.0% per month (12% APR) or $8.00, whichever is greater will be added to your account for balances due past 30 days.
- **MINOR PATIENTS**: The adult accompanying the minor (under 18 years of age) is responsible for full payment of the services provided. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.
- **MISSED APPOINTMENTS:** For the courtesy of other patients that are waiting for appointment times, please be aware that we require 48 hours' notice to change or cancel an appointment to avoid a charge.

## Payment Options:

- Complete payment in advance: For qualified patients we offer a **5% bookkeeping courtesy reduction** when the total amount for all phases of your proposed treatment plan is paid in full by **cash or check** BEFORE the first appointment.
- We accept: **DISCOVER, VISA, MASTERCARD, CASH, OR CHECK**
- Healthcare Financing: Upon approval of credit, including a 12 month option.

## CONSENT FOR CARE:

I request the consultation services of Perfect Smles, LLC. I authorize the doctor to take any necessary x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of treatment needs. I understand this may include consultation with my physician or other practice specialist. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

______________________ ______________________

Date Patient Printed Name

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Patient Signature

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