OAK PARK
DENTAL STUDIO

Practice Guidelines

APPOINTMENTS

Appointments scheduled for your visits are time reserved specifically with your treatment needs in mind. Please make every effort to be on time so that we can ensure adequate time for your care as well as for other patients in our schedule.

We believe that your reserved dental appointments represent a shared responsibility for both the doctor and the patient. In order for us to continue to provide quality dental care at an affordable cost, these reserved appointments must be kept.

As a courtesy, we may contact you by phone or email to verify that you will in fact be honoring your reserved dental appointment. If we leave you a message, we ask that you return our message to verify your reserved appointment time. If you fail to contact us to verify your reserved appointment, we reserve the right to cancel your appointment and those of your family members. After two (2) Failed Appointments, we will no longer be able to reserve appointment time for you in advance.

First appointments and any emergency visits are paid for by the patient at the time of service, regardless of insurance coverage. You have the option of having us complete your insurance forms and forward them to your insurance company.

CHANGES & CANCELLATIONS

A minimum 48-hour advance notice is required to cancel or change an appointment. Should you fail to give proper notice, you are subject to a Failed Appointment Fee of $57.

INSURANCE INFORMATION

As a courtesy to you, we will be happy to file the necessary forms to help you receive the full benefits of your coverage. **However, we can make no guarantee of any estimated coverage.**

Our office accepts "Assignments of Benefits" from your insurance company. If your insurance company is expected to pay for a portion of your bill, we will wait for that portion from them. It is your responsibility to pay co-pays, deductibles, and any amount not expected from your insurance carrier at the time treatment is provided.

If your insurance carrier does not pay the balance within sixty (60) days of treatment, the balance on your account will become your sole responsibility. Please be aware that some, and perhaps all, of the services we provide to you may be "non-covered" services and may not be considered "necessary" under your insurance plan. An example of such a service is "tooth colored" composite fillings. Many insurance plans only pay for mercury fillings; in such a case, you would be responsible for any difference in cost.

In addition, your insurance carrier may pay based upon fees considered "usual & customary" that differ from our fees. Our practice is committed to providing the best treatment possible for our patients and our fees are based upon this principle. You are responsible for payment in full, regardless of your insurance carrier's arbitrary determination of "usual & customary" fees. Please remember that your insurance plan is a contract between you and your insurance carrier. Our practice is not a party to this contract. You are ultimately responsible for the timely and complete payment of your account balance.

PAYMENT OPTIONS

The following payment options are provided to help make quality dental care affordable to you.

Please select on of the following:

☐ 1. **I do not have insurance**. Payment in full is due on the day of treatment for all service provided.

☐ 2. **I have insurance**. However, I prefer to pay in full for all services provided, and have my insurance company reimburse me directly.

☐ 3. **I have insurance**. I will pay my deductible and the required estimated co-payment at the time treatment is provided. I prefer that my insurance company reimburse you directly. I will provide a Credit Card Authorization to cover any difference between the estimated benefit, and the actual benefit paid.

I have read the above and understand the terms thereof and agree to the option I have selected.

_____ _____

Patient Signature (signature of guardian if patient is a minor) Date

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Printed Name