3344 N Lincoln Ave
Chicago, IL 60657

P: (773) 549-7971
F:(773) 348-7544

Patient Financial Agreement

Thank you for choosing Belmont Dental Care as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

PLEASE NOTE: Full payment is due at the time of service. If estimated insurance benefits apply, estimated patient co-pays and deductibles are due at the time of service. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit Healthcare Credit Card.

DENTAL INSURANCE: We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. As a courtesy to you, we will submit claims to your insurance on your behalf. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately. A treatment plan estimate is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject various limitations and exclusions such as waiting periods, frequency limitations, and alternate benefit provisions. Your insurance company and your plan benefits ultimately determine the amount paid. All charges you incur are your responsibility, regardless of your insurance coverage or arbitrary usual and customary rates. In order to better assist you, we ask that you please make us aware of any insurance changes prior to your appointment.

MEDICARE/ MEDICAID/ CHAMPUS/ WORKER'S COMPENSATION: If you are covered by Medicare, Medicaid, CHAMPUS, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the office on the date of service.

TIMELY PAYMENT: Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If payment is not received or your claim is denied, you will be responsible for paying any remaining balance. All outstanding account balances past 90 days are forwarded to our collection agency. You are responsible for any additional collection fees applied to your account. Treatment consents and financial agreements must be made prior to appointment or nonemergency treatment may be denied.

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INSUFFICIENT FUNDS: A $35 fee will be applied for check payments returned due to insufficient funds. We reserve the right not to continue to accept personal check payments for accounts with an insufficient funds history.

MISSED APPOINTMENT(S) AND CANCELLATIONS: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we kindly request 2 business days notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in the inability to pre-schedule appointments and, in some cases, being dismissed from the dental practice.

CONSENT: I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

_____
Patient Name

_____
Name of Responsible Party

_____
Signature of Responsible Party Date