

**Belvidere Dental Associates
FINANCIAL POLICY**

Thank you for choosing us as your dental health care provider. Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology. **Please understand that payment of your bill at time of service is considered part of your treatment.** The following is a statement of our financial policy which we require that you read, agree to, and sign prior to any treatment.

Methods of Payment

1. We request payment in full by cash, check, or credit card (MasterCard or Visa).
2. Dental assisted benefits:

If you have dental assisted benefits our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company; therefore, we request that you call your carrier to check the status of your outstanding claims 30 days following treatment. And if payment has not been received from your carrier within 45 days of treatment, we do require that the balance be paid immediately by you. **We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits.**

3. As a courtesy to you, we will file your claim and accept assignment of benefits if you have signed the direct payment authorization form. **We request that your estimated co-payment and deductible be paid at the time of service.**

Related Information

1. We encourage you to seek regular dental care. Preventive dentistry is one of the best investments you can make (i.e. early treatment now can minimize future dental problems and minimize costs of more advanced treatment).
2. A 50% retainer fee is required for all treatment involving laboratory preparation. The remaining 50% will be collected at the final appointment, less any dental assisted benefits. This allows our doctors to meet their ethical and financial obligations to complete your treatment.
3. **If you are unable to keep your commitment for an appointment, we request at least a 24 hour notification.** Please understand that when you schedule an appointment time with us, we have reserved this time just to see you. Please be sure of your availability. We do not "overbook" to protect ourselves from last minute changes and we appreciate your respecting our time and the commitment we have made for your appointment.
4. **I understand that I am responsible and obligated to pay for my treatment regardless of dental assisted benefits. In the event that this account should become delinquent, Belvidere Dental Associates retains the right to collect interest, attorney fees, and any court costs incurred in an attempt to collect this account.**

Patient Signature (Parent if minor)

Date