Best Dental Group

106 W. Bartlett Ave.
Bartlett, Illinois 60103

Financial Policy

Our Dental Practice is proud to be a team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your dental care and want to ensure that it is performed in the most responsible manner. In order to assist you with the investment in your dental health we have outlined our payment policy.

Our policy is that payment is due in full for your liability. (The amount that is not covered by your dental insurance carrier.) For your convenience we accept cash, check, money orders, credit cards and Care Credit and Chase Health Advance (an outside credit source).

For orthodontic accounts, the first consultation is available to our patients at no charge. If further orthodontia is required, we offer an interest free payment plan. Our dental team will be happy to submit your dental insurance for you. Your dental carrier will then reimburse you. There is a limit of four orthodontic brackets replaced at no charge. Every bracket that needs to be replaced there after will incur a charge of $25.00.

We understand the value of insurance benefits that you may receive. Upon receipt of your insurance information, our dental team will gladly verify your dental benefits and inform you of your coverage. We accept direct payment from your insurance carrier, however, we require any known deductible or co-payments at the time of service. Our team will file a claim on your behalf at no charge. *You may wish to pay in full at the time of service in order to take advantage of our* ***5% discount*** *plan. Your dental carrier will them reimburse you.* (This plan is not applicable to financing through an outside credit source or any PPO insurance plans.)

Signing this form allows **Best Dental Group** to secure financing through an outside credit source in the event that your liability is not met within 45 days after services are rendered and after insurance benefits have been received.

An appointment is reserved time specifically for you so we can offer you the highest quality treatment possible. In consideration of all our patients who need to be treated in a timely manner, we require a ***48 hour cancellation*** notice or a $50-$100 will be applied to your bill. (This does not apply to patients with medical emergencies or severe illness). **A seven day notice is required to cancel or change all surgical appointments in order to avoid our cancellation fee.**

If your account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collections including billing and postage. To the extent necessary to determine liability for payment and to obtain reimbursement,. I authorize disclosure of my record. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize said assignee to release all information necessary to secure payments. Our office will implement an automatic $10.00 monthly billing fee for all accounts that are 60 days past due.

I fully understand and agree to the above policy. I was given the opportunity to ask any questions.

______________________________ ______________________________

Patient/Parent or Guardian Date Witness Date