

A Dental Place, LTD  
Dan Fong, D.D.S.  
845 S. Main St. Ste 202, Lombard, IL 60148

Dear Patient:

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask our office manager.

***Dr. Fong provides treatment for what is best for you and your oral health, not according to what your insurance company will cover.***

#### FINANCIAL GUIDELINES

1. Your dental insurance policy is a **contract between you, your employer, and the insurance company**, we are **NOT** a party to that contract. Our financial relationship is with **you**, not your insurance company. **All charges are ultimately your responsibility whether your insurance company pays or not.**
2. Dental insurance is **not** a pay it all, it is only meant to be an aid. Not all services are a covered benefits in all contracts. Some insurance companies randomly select certain services they will not cover. It is **your** responsibility to know your insurance coverage and benefits.
3. Fees (co-pays) for services, along with unpaid deductibles, and previous balances are due at the time of treatment.
4. If the insurance company does not pay within 30 days, we may ask that you contact your carrier to help speed things up. If your insurance company does not pay within 45 days, we may require you to pay the balance due.
5. Balances older than 90 days may be subject to additional collection fees and interest charges of 1.5% per month.
6. Returned checks (NSF) will have an additional fee of \$35.00 added to the amount of that returned check, and we will no longer accept your checks.

**Payment for service is due at the time services are rendered.** We accept cash, personal checks, MasterCard, Visa & Discover. We will process your insurance claim for reimbursement as long as you have complete, up to date insurance information. As a convenience to you, we will accept assignments of insurance benefits but you will still be required to pay any fees (co-pays) due.

Confirmation calls are a courtesy; you are responsible for remembering your appointment date and time. Please contact the office as soon as possible if you need to cancel or reschedule. ***Please note: 7am & 7:45am appointments not canceled or rescheduled at least 48 hours (2 days) in advance will be charged a fee of \$75.00; all other appointment times is \$50.00.***

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing our dental office as your dental health care provider. We appreciate your confidence in us, and the opportunity to serve you.

Patient's (Parent/Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_