Illiana Endodontics, Inc.

Dental Office Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:
Understand that (regardless of any insurance status) you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

Missed appointments:
Unless we receive notice of cancellation 24 hours in advance, you will be charged $50.00. Please help us service you better by keeping scheduled appointments.

Insurance:
Please remember your insurance policy is a contract between you and your insurance company. **We are not a party to that contract**.

As a courtesy to you, our office provides certain services including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment Options Are:

- Option 1: Payment in Full and receive a 5% discount.
- Option 2: $200/$300 Deposit and we will file your insurance. Balance must be paid within 90 days (guaranteed with a credit card or check converted to electronic transaction).
- Option 3: Care Credit application and receive 3 months no interest or extended period with minimal interest added.

Unpaid balances over 90 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for collection, attorney and court costs associated with recovery of monies due on the account. There will be a fee for all returned checks.

Credit Card # _____ Exp._____ CUV# _____

I have read and understand the financial policy of Illiana Endodontics, Inc.

Signature _____ Date _____