Bucktown Dental Associates

Financial Policy

Thank you for choosing our office. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Did You Know?

- We offer many financing options through CareCredit & Lending Club. Some plans offer **interest free financing** *(subject to credit approval).*
- We offer a **5% courtesy discount** on treatment over $500.

Non-insured patients

- Payment in full is due at the time services are rendered unless prior financial arrangements have been made.
- We accept Visa, MasterCard, Debit, Personal cheques, Cash, CareCredit, and Lending Club. .
- Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee.
- A 1.5% monthly administrative fee and $5 billing fee will be added to balances not paid in 30 days.
- If account is not paid within 90 days of service and no financial arrangements have been made, I understand that I will be responsible for legal and collection fees in addition to interest and all other expenses incurred in collecting my account.

Insured Patients

- As a courtesy to you, we will help you process your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid.
- All charges you incur are your responsibility, regardless of your insurance coverage. 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.

Initials_____

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unless you have a PPO plan in which Dr. Elseweifi is an in-network provider, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Deposit Policy

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a deposit of 50% of the treatment fee to make your reservation. If you have insurance, we require paying your copayment to make your reservation.

In-office Orthodontic Financing

If we extent in-office financing for orthodontic treatment to you, we do so by automatic monthly charges. We require a credit card to be on file for such charges.

Bucktown Smile Club Discount Dental Plan

If you don't have dental insurance, we offer a discount dental plan called "Bucktown Smile Club." Our plan provides low cost dental care and all the rewards of dental insurance without the headaches. Every family member can join too. Asks us about how you can join. This is not an insurance plan.

Minors accompanied by the parent or legal guardian:

The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Initials_____

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 require at least a 48-hour 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 being dismissed from the dental practice.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. 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.
Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient /Parent name printed _____

Patient /Parent signature _____ **Date**_____