

Batavia Family Dental
239 W. Wilson Street Batavia, IL 60510
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www.bataviadentistry.com

Our Financial Policy

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care, and successful financial arrangements are part of successful, predictable treatment results. Successful financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and or patient's financial capabilities. Please read and sign the following:

Payment

Payment in full for your **estimated** insurance co-payment is due at the time your visit, unless other arrangements have been made with the Business Administrator. Please be prepared to pay. We accept the following forms of payment:

- Cash, Check, Debit, Visa, MasterCard and Discover
- We offer financing with Care Credit
- We offer monthly payment plans through automatic deductions

Insurance

Our office is committed to helping out patients maximize their benefits. Dental insurance is becoming extremely complex. We are always available to attempt to answer your questions. Nevertheless, your insurance policy is a contract between you and your insurance company. As a dental provider, we are not party to that agreement. **Your patient portion must be paid at the time of service.** As a service to our patients, if you bring in all your insurance information, we will bill your insurance company. If you can not provide us with necessary insurance information, payments in full is expected and you will need to bill your insurance for reimbursement. The quality of insurance policies varies greatly, **therefore we can only estimate your coverage in good faith**, but can not provide any guaranteed coverage due to the complexities of the insurance contracts. Any and all estimates presented to you are based on current insurance information made available to our office by you and your insurance company. Should this information be inaccurate, you will be responsible for the all balance(s) left unpaid.

Minors

Payments for services of the treatment of minors is the responsibility of the adult accompanying that minor.

Service Fees

· Missed/Late Appointments- fee \$50. A 24 hour notice is necessary to avoid this charge. Once an appointment has been made, please remember that this time has been reserved specifically for you. If you will be late or unable to attend a scheduled appointment, please call us. We will be glad to reschedule your appointment. **To avoid any missed appointment or cancellation fees, we require 24 hours notice.** If you miss a schedule appointment or fail to notify us in advance, a missed appointment fee will be charged to your account.

Service Charge

We charge a \$35 fee for returned checks which you are responsible for.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Signature of patient (**Print name of patient is patient is a minor**) Signature of Responsible Party (if patient is a minor)

Signature on File

This patient agrees to be fully responsible for total payments of treatment performed in this office. I understand and agree to this Financial Policy and Agreement. I authorize release of any information related to this claim or any insurance information. I understand that I am responsible for all dental treatment not covered by my insurance and failure to remit payment can and will result in forwarding my account to collections. I hereby authorize payment directly to Batavia Family Dental, for the group benefits otherwise payable to me

Signature of patient/responsible party

Date

Print name of Patient (if under 18 years old)

Print name of Guardian (if patient is under 18 years old)