

West Suburban Family Dental

Patient Acknowledgements, Agreements & Authorizations

West Suburban Family Dental is committed to providing all patients with exceptional service and care. We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so we may help you fully understand our office policies.

CONSENT FOR TREATMENT

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL BENEFITS

- I understand that ultimate responsibility of determining and understanding the details, restrictions and limitations of my insurance is my responsibility.
- I will provide West Suburban Family Dental with the most updated information, in detail, concerning my dental insurance(s).
- I authorize and request that my dental insurance company pay directly to West Suburban Family Dental P.C.
- I understand that any pre-estimate, either determined by West Suburban Family Dental or by my insurance company is not a guarantee of payment. Insurance payment received is determined by my eligibility at the time of treatment, deductibles, yearly maximum, family maximum and any other of the many criteria for my insurance company uses to determine benefits.
- I acknowledge that West Suburban cannot guarantee payment or be held responsible for multiple inquiries or requests by my insurance company. I understand that my insurance company may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services performed on my behalf or my dependents.
- I understand that, as a courtesy West Suburban Family Dental will provide the service of completing, submitting and receiving payments from my insurance company. **However, if the balance is not paid by my insurance after 90 days, I understand that I will be wholly responsible for any amount that has not been paid by my insurance.**

FINANCIAL AGREEMENT (FOR ALL PATIENTS)

- I understand that upon acceptance of treatment in this office I assume financial responsibility for payment of all fees.
- I understand that payment is due at the time of service unless other arrangements have been discussed and finalized. This payment may be in the form of Cash, Check, Visa, MasterCard, Discover, American Express or Care Credit.

PHONE

FAX

WEB

- I understand that for comprehensive treatment plans requiring multiple office visits, West Suburban Family Dental requires a minimum of **60%** of the total estimated patient portion of the fees at the start of treatment.
- I understand that I may, at my discretion, elect to pay in full, in advance for comprehensive treatment plans.
- I understand that no future services will be provided until pending balances for previous services are paid for.
- I understand that it is my responsibility to inform West Suburban Family Dental of any changes in my health information as well as my address, phone, email, or insurance information.

REGARDING APPOINTMENTS

Our time is valuable and so is yours. Our commitment to you is:

- ❖ We will always try to make appointments that are convenient for you.
- ❖ We will not ask you to make a schedule change unless it is an extreme emergency.
- ❖ We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Patient Acknowledgment:

- I understand that West Suburban Family Dental reserves chair time specifically for me. I understand that I must give the office **48 hours** (or more) notice if I need to change or cancel my appointment.
- I understand that West Suburban Family Dental does NOT accept cancellations or changes to appointments after hours via voicemail. I acknowledge that I must call the office during normal business hours to change my appointment.
- I accept that a fee of **\$50** will be charged to my account for all broken/failed appointments or cancellation without sufficient notice.
- I understand that appointments that I arrive to **15 minutes** or later after my scheduled appointment time will be considered a broken/failed appointment and treated accordingly.
- A fee of **\$25** will be charged to my account for any checks that is returned due to insufficient funds, stop payment or closed accounts.