Aesthetic & Reconstructive Dental Associates
OFFICE GUIDELINES

CONSENT
I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I understand that I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements, if necessary, will be agreed upon before treatment is started.

If care is being rendered on a minor, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for the payment.

Patient initials _____

DENTAL INSURANCE
We are happy to submit insurance claims on your behalf; however, **we cannot guarantee any estimated coverage from your insurance company**. Unless prior arrangements are made, you will be expected to pay your portion as services are provided**. You are responsible for any remaining balance on your account after the insurance company has made payment.** Because your insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over a claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits. Any balances not paid by the insurance company within 60 days of submission become the patient's responsibility.

Patient initials _____

FINANCIAL RESPONSIBILITY
1. Balances remaining beyond (30) days from first bill will accrue interest at a rate of 1.5% per month (18% annual rate) unless other financial arrangements have been made.
2. There is a charge for all returned checks. This charge will be in the amount of the maximum allowed by the Illinois state statute.
3. Personal credit may be checked.
4. In the event of default I promise to pay legal interest on the indebtedness, collection costs, and related attorney's fees.

Patient initials _____

PAYMENT OPTIONS
Cash, check and credit cards are accepted for payment in our office. We also offer third party financing and in-house financing for those patients who qualify. **If treatment is started without any financial arrangement I understand that I am to pay for the treatment in full at the time service is rendered.**

Patient initials _____

CANCELLATION POLICY
In order for this office to continue to accept discounted insurance plans, and out of respect for appointment availability for other patients, **I understand that this office has a cancellation policy.** If I am unable to keep a previously scheduled appointment and I do not provide the office at least two business days notice, I will be charged a **$60.00 broken appointment fee *per half hour of scheduled time*** for any missed appointment.

Patient signature _____

**For patients with unpredictable schedules, please ask a team member for details about our "Short Notice" Program.*

APPOINTMENT CONFIRMATIONS AND REMINDERS
Our office utilizes an automatic appointment confirmation and reminder system. The system will ask you to respond to our office, either via email or telephone. We would like to know which method you prefer to be reminded of your appointments. *(Please select your preference)*:

☐ Text message ☐ Email ☐ Both ☐ I don't receive text messages or emails

Patient's Signature Date