LINCOLN WAY FAMILY DENTAL

FINANCIAL POLICY

Thank you for choosing Lincoln Way Family Dental as your dental health care provider. Our office is committed to providing you with the best possible care. We would like our patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment for services is due at the time of treatment. We desire to make dental treatment affordable to all of our patients; therefore, we offer the following payment options:

1) Cash, Check, Visa, Mastercard or Discover
2) Care Credit. Approval must be received prior treatment date.
3) Payment Plans: Available for large treatment plans. Please see front desk.

Insurance Policy

We request that any co-payments, deductibles, and services that are not covered by your insurance plan be paid at the time the service is provided. Your claim will be filed immediately, and benefits are expected to be paid within 60 days. The filing of an insurance claim does not relieve you of timely payment on your account. The balance is your responsibility whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company and we are not a party to the contract**. If your insurance company has not paid your account in full within 60 days, you will be responsible for the balance.

Rescheduling/Cancellation Policy

Our practice is dedicated to quality care and exceptional service. Your appointment time is reserved for you and broken/missed appointments create scheduling problems for our team as well as other patients.

If you find that you must change your appointment, we require a minimum of 24 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee of $50.00 will be charged to your account.

Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office for a $10 fee.

Returned Check Policy

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check.

I have read and agree to the Financial Policy and the Cancellation Policy as listed above.

Patient Name: _____

Signature: _____ Date: _____