



FINANCIAL POLICY

Thank you for choosing Lincoln Way Family Dental as your dental healthcare provider. Our office is committed to providing you with the best care possible. We would like our patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins.

In an effort to make treatment affordable to our patients, we offer the following payment options:

- 1) Cash, Check, Visa, MasterCard, Discover, or American Express
- 2) Care Credit: Approval must be received prior to the treatment date.
- 3) Payment Plans: May be available for large treatment plans.

Payment for services is always due at the time of treatment.

Insurance Policy

We are out of network with all insurance providers; however, we will gladly file insurance claims on your behalf for any PPO policies. While we do our best to accurately **estimate** your insurance benefits based on the information we have at the time services are rendered, it is possible that the estimate will differ from what insurance actually pays. If payment from insurance differs from what was expected, you will either receive a statement from our office for the balance due or a refund will be posted to your account. Please note that all charges incurred in our office are your responsibility. Your insurance policy is a contract between you, your employer, and the insurance company and we are not a party to that contract.

Payment is due for all deductibles and co-payments at the time services are rendered.

Rescheduling/Cancellation Policy

Our practice is dedicated to quality care and exceptional service. When we schedule your appointment, the time is reserved exclusively for you.

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 \$75.00 may be applied to your account.

Our office reserves the right to limit future appointments or dismiss patients if short-notice cancellations or no-shows occur more than twice.

If your schedule makes it difficult to plan, we ask that you do not schedule an appointment in advance, but that you call us on a day you are available, and we will let you know if the time is open in our schedule.

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 with the Financial Policy and the Cancellation Policy as listed above.

Patient Name: _____

Signature: _____ Date: _____