



FINANCIAL POLICY

Thank you for choosing us as your dental provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Payment for services is due at the time services are rendered. We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover and American Express.

The parent that accompanies the minor child/children to the appointment is responsible for payment due. For the unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a \$20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your employer. We are not a party to that contract. We will, however, be happy to serve as a liaison and file your claim to your insurance company for you. Your insurance company should then reimburse you directly, usually within 7-10 business days.

For those insurances in which Growing Smiles is a participating provider, we require a credit card on file. The patient will be responsible for paying the percentage of outlined fees set by their insurance company at the time of service. If your insurance company has not paid your account in full within 60 days, you will then be responsible for the remaining balance.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and considered reasonable and customary under the terms of your insurance policy. Our practice is committed to recommending the best treatment for our patients regardless of coverage. We charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. As a reminder, all fees are due at the time of service. Thank you!

Assignment of Benefits

For participating insurance companies: I hereby instruct and direct that **Delta Dental / Cigna Dental** Insurance Company is to pay by check made out and mailed to:

Growing Smiles
3701 N Southport
Chicago, IL 60613

Please initial stating you understand the insurance check will come to our office.

For non-participating insurance plans: I hereby instruct and direct you to make out the check to me and mail to the address I have on file.

Please initial stating you are responsible for payment at time of service, and your insurance company will reimburse you with a check to the address you have on file with them.

This is the direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay within 30 days, the full balance of said professional service charges over and above the insurance policy.

A photocopy of this assignment shall be considered effective and valid. I also authorize the release of any information pertinent to my case to an insurance company, adjuster, or attorney involved in this case.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Cancellation/Rescheduling Policy

Children tend to do better in the dental office when they are not tired. Therefore, we encourage morning appointments, especially for pre-school aged or nervous children. One of our goals is providing dentistry that is as pleasant as possible for your child, and appropriate scheduling may help us achieve this goal. Also keep in mind that a dental appointment is an excused absence from school.

When we schedule an appointment, that time is reserved solely for your child and we make every effort to see your child on time. For this reason, we ask that you arrive a few minutes before your scheduled time. If you are late, it may be necessary to reschedule your child's visit. We also require a 24-hour notice for cancellations. We need this amount of time so that we may contact a child from our waiting list to offer the appointment. If we do not receive a 24-hour notice, we reserve the right to charge your account a broken appointment fee.

You agree that by checking "Electronic Signature" such action will constitute your electronic signature having same legal force and effect as a hand written signature.

I have read the Office Policy. I understand and agree to this Office Policy.

Signature of Parent or Responsible Party: _____

Date: _____