Prairie Meadows Dental
2323 Randall Road – Carpentersville, Il 60110
847-426-6520

PAYMENT POLICY

UNINSURED PATIENTS

Routine Cleanings & Check-ups, Perio Treatment, and Minor Restorations: Payment is due in full on the day of treatment

Major Restorations: ½ of the total is due on the day of treatment. The balance is due in full on the day of final treatment.

INSURED PATIENTS

It can be very challenging understanding your dental insurance coverage. Our goal is to assist you in maximizing your insurance benefits. We care for patients with coverage from many different companies. Each company has its own schedule of benefits and exclusions, which means that each company may pay a different amount for a specific procedure. Please be aware that the estimate we receive from your insurance company is just an estimate. The insurance company has the final decisions on what they will pay and what they won't. Many insurance companies have exclusions and limitations. We encourage you to become familiar with your dental insurance plan.

As a courtesy to you we will research your dental insurance plan to advise you, as best we can, regarding your coverage. We will file your insurance benefits within 24 hours of your visit to our office and re-file your insurance claim if we do not receive payment from the insurance company within 30 days.

Routine Cleanings and check-ups: Most insurance companies cover 2 routine cleanings per year. No payment is due on the day of treatment. If applicable, you will be billed for any balance.

All Other Treatment: Our computer system estimates your coverage. **Payment of your portion is due, in full, on the date of treatment**. If your insurance company pays less than estimated you will be billed for any remaining balance. If your insurance company pays more than estimated, you will receive a refund.

Methods of Payment

We accept cash, check, Visa, MasterCard, Discover and American Express. For your convenience, you may authorize us to automatically charge your monthly payment to your credit card. To qualifying patients, a **payment plan** may be arranged in advance of treatment. There will be a $25 charge for returned checks.

MISSED APPOINTMENT POLICY

Every appointment is valuable to us and our patients. In order to avoid a missed appointment fee of $50, kindly provide us with a minimum of 24-hours notice if you need to cancel or reschedule your appointment.

AUTHORIZATION

I have read, understand, and agree to the above policies. I hereby authorize and request my insurance company to pay direct to the Dental Office any group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure the payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of this signature on all insurance submissions.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed with a collection agency, for collection or any subsequent legal action, to pay an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

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SIGNATURE OF PATIENT (PARENT or GUARDIAN if a minor)   **DATE**