WILLIAM H. SLAVIN D.D.S.

One North Main Street – Manteno, IL 60950
Phone: (815) 468-8832

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to sign prior to any treatment.

Payment for Services
Payment for all services is due at the time services are rendered unless alternate arrangements for payment have been made with our staff in advance. All co-pays must be made at the time of service according to contract.

Regarding Insurance
If you have dental insurance, we are happy to help you receive the maximum allowable benefit. In that regard, we will provide you with all of the information necessary to file a claim, or if you prefer, we will file a claim for you. In either case, it is important to understand that, as a health care provider, **our relationship is with you and not with your insurance company.** As a result, **it is the patient who is ultimately responsible for any and all charges not covered (for whatever reason) by insurance.**

I request that Medicare, Medicaid, and/or other insurance benefits be made on my behalf to Dr. William H. Slavin for any services furnished me in his office. I authorize any holder of dental information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Minor Patients
The adult accompanying a minor and the parents/guardians of the minor child are responsible for payment of any and all charges not covered by insurance.

Missed Appointments
Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments or by rescheduling in a timely manner.

AUTHORIZATION AND RELEASE

I (we) have read and understand the financial policy of the office of Dr. William H. Slavin set out above. Specifically, I (we) understand that I (we) am/are responsible for any and all charges not paid by insurance within 60 days. Should it become necessary for the office of Dr. William H. Slavin to turn my account over to a collection agency or attorney, I (we) understand that I (we) will also be responsible for any costs of collection, including reasonable attorney fees.

I (we) understand that this Authorization and Release shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this day forward until it is revoked in writing.

_____ _____
Patient Signature **Responsible Party (Parent/Guardian) Signature**

Dental Record # _____ **Patient #** _____

FINANCIAL POLICY CONTINUED

Payment is due at the time of treatment. We accept cash, check, Visa, MasterCard and Discover. We also offer a flexible payment plan, **CareCredit,** which allows you to start your treatment today and spread payments over time. Applying for **CareCredit** only takes a few minutes and there is no fee to apply. With **CareCredit,** we do not require any payment today.

We ask that you provide us with a **Credit Card number, CareCredit CitiCare or HealthCare Creditline number to transfer any unpaid balances over 30 days**. We bill you directly once. If the balance in not paid in full within 30 day (of the statement date), the balance will be placed on the below card. Please fill the following:

Account Number:_____Exp. Date:_____
Visa/MasterCard/Discover/American Express/CareCredit (circle one)

_____Date:_____
Cardholder's Signature

ADDITIONAL INFORMATION

- **SERVICE CHARGE:** $25 will be assessed on all **returned checks.**
- **DIVORCE:** After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **TRANSFERRING OF RECORDS:** You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor to us, you authorize us to receive all relevant information, including your payment history.
- **MISSED APPONTMENTS:** Patients with three missed appointments will be asked to transfer their records to another doctor.
- **TREATMENT INVOLVING LABORATORY FEES:** (crowns, bridges, dentures, etc.) 50% of the fee is due on the preparation date (initial appointment) and the other 50% must be paid on or before the deliver date (final appointment).
- **WORKERS COMPENSATION:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.
- **PERSONAL INJURY:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. We cannot bill your attorney for charges incurred due to a personal injury case.

_____ Date:_____
Signature of patient/responsible party