



Fox Valley Dental Care, LL.C.

74 N. Alfred
Elgin, Il. 60123

phone: 847- 695- 1300
www.fvdc.com

FINANCIAL POLICY

Thank you for choosing Fox Valley Dental Care, LLC for your dental care. We are committed to giving for the finest treatment available. Please understand that payment of your bill in a prompt and timely manner is necessary in order for us to continue to offer the best in dental care at reasonable prices. If you have any questions regarding your treatment or our financial policy, please ask the doctor or a member of our staff.

Regarding Insurance: While we may accept an assignment of insurance benefits after your initial visit, it is important for you to understand that you are ultimately responsible for paying the outstanding balance on your account for your treatment, regardless of whether your insurance company pays or not. In order to process your claim, we will need your insurance information and possibly an original claim form, depending upon the insurance company and your specific circumstances. You are expected to pay your applicable deductible and co-payment at the time of service. Please be aware that some (and perhaps all) of the services provided may not be covered under your insurance policy; in the past, some insurance companies have denied a patient insurance coverage for certain services.

Our fees are usual and customary for our area, and thus it is important to remind you that you are responsible for payment regardless of your insurance company's determination of usual and customary rates. Also, keep in mind that your insurance policy is essentially a contract between you and your insurance company, and that we are not a party to that contract. If your insurance company is to continue your coverage, you must comply with the terms of your insurance policy contract.

Missed appointments: As you would expect, we ask you to give us as much lead notice as possible if you need to cancel your appointment. Please note that unless an appointment is canceled by you at least 24 hours in advance, we reserve the right to charge for missed appointments.

Past Due Balances: Any account that has become unreasonably delinquent will be assessed a \$10.00 billing fee. Additionally, you will be responsible for any and all cost of collection for unpaid balances, including, but not limited to collection agency fees, reasonable attorney's fees, and court costs.

"I have read the financial policy as outlined above. I understand and agree to this financial policy."

(signature of patient or responsible party)

Date: _____