

# Lindenhurst Dental Health Group

1909 E GRAND AVE SUITE A | LINDENHURST IL, 60046 | (847) 356-0260

## Written Financial Policy

Thank you for choosing Lindenhurst Dental Health Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

### Payment Options:

You can choose from:

- Cash, Visa<sup>®</sup>, MasterCard<sup>®</sup>, American Express<sup>®</sup> or Discover Card<sup>®</sup>
- CareCredit Healthcare Credit Card

Please note:

Lindenhurst Dental Health Group requires payment at the beginning of your treatment.

We accept payment in thirds for treatments over \$1000., Only when a Credit Card Monthly Auto-Charge Authorization form is completed.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment,(see note 1) however your estimated co-payment is due in full at the time of service.

A fee of \$50.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Lindenhurst Dental Health Group charges \$25.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)

- 1.) However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Lindenhurst, IL 60046**

**As a courtesy and added service to our patients, we are pleased to accept insurance assignment as a form of payment. However, it must be clearly understood that the “contract” is between you (the patient) and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.**

**The following are our policies that govern insurance claims:**

- As a courtesy to you, we will contact your insurance to determine eligibility and benefits, but we are not responsible for the information received, as the insurance company will not guarantee it. All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.**
- You (the patient) or the financially responsible party, will pay all co-pays or the estimated portion of your charge not covered by the insurance company. This portion is due in full at the time of service in order for us to accept your insurance as a form of payment.**
- All insurance information must be complete. If incomplete, we will be unable to appropriately bill the insurance company and the responsibility for payment then becomes that of the patient.**
- Our office does NOT guarantee that your insurance company will pay on claims. We will perform routine insurance procedures upon verification of coverage. However, if for some reason your insurance company pays differently than determined at the time of your visit, or your insurance claim is denied, you (the patient) are then considered to be responsible for the full amount of the bill.**
- Insurance payments ordinarily are received within 30 to 60 days from the time of submission. If your insurance company has not made payment to our office within 90 days, we request that you (the patient) pay the balance due, and then seek reimbursement from the insurance company when and if it pays.**
- Our office will not enter into a “dispute” with an insurance company over a claim, although we will work with the insurance company to sort out any confusion or questions that may arise. If necessary we will request that you contact your insurance company to assist with the resolution of any problems over payment.**

**I, \_\_\_\_\_ CONFIRM THAT ON \_\_\_\_\_ I HAVE  
READ/ UNDERSTAND AND AGREE TO ADHERE TO THE ABOVE STATED  
INSURANCE POLICIES**