PAYMENT POLICY

Welcome to Northern Illinois Endodontics. Please read these payment policies and feel free to ask us any questions that you may have.

We participate in the following insurance plans: Delta Dental Premier, Cigna PPO and MetLife. However, we will file your insurance as a courtesy to you. **It is your responsibility to provide us with a current, valid dental insurance card at the time of your visit. A deposit will be required for treatment. We will bill you for any balance that remains after the insurance payment has been received. If you have any questions concerning your insurance coverage or benefits, please contact your insurance company. Please understand that you, the patient, are ultimately responsible for payment for any endodontic services received.**

If you do not have dental insurance, payment is due at the time of your appointment. A fee of $25.00 will be charged for any checks returned for insufficient funds.

Statements are mailed on a monthly cycle. Payment is due by the first of the following month. A $10.00 late fee will be added to the past due accounts. If a payment still is not received by the first of the next month an additional $10.00 late fee will be charged. Delinquent accounts will be referred to a collection agency. When your account is referred to a collection agency a fee will be added to the outstanding balance, plus additional court costs and attorney fees if needed.

If your treatment is the result of an accident, and you would like your claim handled by a non-dental insurance policy, payment is required at the time of treatment. We will provide you with the forms to submit your claim for reimbursement.

I acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at or before completion, unless other specific arrangements are made with the office manager. I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize the release of any information necessary to process my dental insurance.

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Initial

INFORMED CONSENT

I understand that my written informed consent is required to allow this office to take radiographs, conduct a thorough examination and provide treatment options. I authorize the doctor to administer anesthesia and perform root canal therapy as needed. I also understand that Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth that has had Root Canal Therapy may require retreatment, surgery, or even extraction. I also understand that **only** the Root Canal Therapy is to be performed at this office. The **permanent** (outside) **restoration** (filling, onlay, crown, etc.) will be done by my regular dentist.

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Initial

Signature of Patient or Guardian Date