

TALL GRASS DENTAL ASSOC.

A COSMETIC AND GENERAL DENTAL STUDIO

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OFFICE POLICY DISCLOSURE & CONSENTS

MISSED APPOINTMENT FEE

- I agree to pay a fee to Tall Grass Dental Assoc. for failing to keep an appointment without notification 3 office days before the scheduled appointment.

INSURANCE, PAYMENTS, AND FEES

- We will file your dental insurance claims for you.
- If sending a minor alone for services I will provide the office with a credit charge to cover the fees for the appointment.
- I agree to pay all estimated co-payments and deductibles at the time of service.
- I agree to notify the office of any changes in my insurance status prior to services being rendered.
- I agree to be financially responsible for my balance if my insurance company does not make payment in 45 days from the date of service.
- I agree to be financially responsible for my balance if my insurance company does not pay the balance in full.
- I agree to pay a fee for the collection of my outstanding balance over 60 days. (Fee is 35% of balance.)

PRIVACY POLICY

- I authorize appointment information to be left on my telephone answering machine or cell phone voice mail.
- I authorize Tall Grass Dental Assoc. and its agents to communicate with any third parties (i.e. insurance carriers or other doctors) as deemed necessary regarding my health and financial information. And I authorize any third party to communicate my health and financial information to Tall Grass Dental Assoc.
- I allow Tall Grass Dental Assoc. to use any photographs taken for educational and promotional purposes, without compensation.

CHANGES TO TREATMENT PLANS

- Treatment plans are estimates only. Dental conditions may be worse than they appear in exams and in x-rays. Fillings may be deep enough to require root canal treatment. Sealants may become fillings. Fillings may be large enough to require crowns. Filling may become sensitive after a few weeks or months and require root canals and/or crowns. Conditions may require treatment from specialists.
- I agree to be financially responsible for all fees that result from a change in my treatment plan.

PRINT ALL PATIENTS' NAMES

I am the person with legal authority to consent to treatment and billing regarding these patients and I understand the previous terms and conditions and agree to be bound by them.

CHOOSE METHOD OF PAYMENT BY INITIALING

CHECK, CASH OR CREDIT CARD _____ OFFICE FINANCING PLAN _____

PRINT NAME: _____

SIGNATURE: _____ DATE: _____