WELCOME TO

PORTAGE PARK DENTAL ASSOCIATES, LTD

5613 W. Irving Park Rd.
Chicago, IL 60634

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please read this form completely. If you have any questions or need assistance, please ask us, we will be happy to help.

TERMS AND PAYMENT POLICIES

1. **PAYMENT OPTIONS AND TERMS (please select one).**

___ I have insurance and opt to pay the bill in full on the day that treatment is rendered. If requested, Portage Park Dental shall process your insurance claim and direct that any benefits be paid directly to you.

___ I have insurance and ask that you submit a claim to my insurance company. On the day treatment is rendered, I agree to pay any co-payments, deductibles or bills for services not covered by my insurance company. The above not withstanding, bills under $200 are to be paid in full on the date services are rendered and Portage Park Dental shall request that your insurer send any reimbursements directly to you.

___ I have no insurance and agree to pay for all ordinary services rendered to me on the day the services are rendered.

2. EXTENSIVE/PROSTHETIC TREATMENT. The above not withstanding, extensive/prosthetic treatment (e.g. crowns, bridges, dentures, etc. and the services to prepare and install them) shall be paid 50% on or before the date the dental appliances are ordered with any balance to be paid before the appliances are installed or the extensive treatment is completed.

3. FINANCING. Portage Park Dental offers financing through Care Credit for extensive treatments. Please inquire for more details.

4. INSURANCE. Upon request, we will gladly assist you by submitting an insurance claim to your insurance company. You remain responsible, however, for tracking your benefits and coverage thereafter. You will be responsible for any part of the bill not paid by your insurer including co-payments, services not covered by your insurer, and insurance deductibles.

5. CANCELLATION FEE. Your appointment time is reserved exclusively for you. If you are unable to come for your appointment, you must notify us at least 24 hours in advance or you will be charged **$60.00**.

6. CHECKS. Personal checks up to $350 shall be accepted for services rendered. Payments above this amount must be made by credit card or cashier's check. Checks returned for any reason shall be assessed a $35 returned check fee.

7. COLLECTION FEES AND COSTS. All invoices are due within 30 days after the date they are issued. Any invoice left unpaid more than 30 days after issuance shall accrue interest at the rate of 9.0% per annum. If the account is referred for collection, you agree to pay all costs of collection, including reasonable attorney fees and court costs.

8. RECORDS AND X-RAYS. All records and X-rays are the legal property of Portage Park Dental. You have a right to copies of these records that will be provided upon payment of copying fees.

9. BILLING FEES. If we bill you for your deductible or co-payments, there is $5 billing charge.

I AM THE PATIENT OR PERSON RESPONSIBLE FOR THE PATIENT. I HAVE READ THE FOREGOING TERMS AND POLICIES AND AGREE TO BE BOUND BY THEM.

Signature:_____ Date:_____
Patient/Responsible Party

Patient Name:_____ Responsible Person:_____

Address*:_____

City/State/Zip*:_____

Email Address*:_____

Phone number*:_____

* Provide responsible party information if someone other than the patient is responsible for the patient or the patient's bill. Otherwise, please provide patient information.

Future Appointments:

Please remind me about my next appointment by: □email □text □phone call

Billing Information:

Credit Card Information: _____ Exp._____ Security code_____

Patient Social Security No.:_____

In Case of Emergency:

Emergency Contact Person: _____

Phone number_____

How did you find out about our office?

□Family/friend □Radio □Television □Online □Walk in
□Other: _____

PORTAGE PARK DENTAL ASSOCIATES, LTD.
CREDIT CARD AUTHORIZATION FOR INSURANCE BALANCES

I authorize PORTAGE PARK DENTAL ASSOCIATES, LTD. ("Portage Park") to charge my credit card for balances due for services rendered to me or others at my request that are not covered by insurance. Portage Park shall use reasonable efforts to process insurance claims on my behalf before charging my card. My credit card shall be charged at such time as my insurance company informs Portage Park of the amount of each bill that will not be covered. These charges may include sums representing a deductible, co-payments, or services not covered by my insurance company.

This authorization is limited to Portage Park and its affiliates and is not transferable or assignable. This authorization shall remain in effect until cancelled. To cancel, I must give 30-days written notice to Portage Park and my account must be current at the time that notice is given.

Type of Credit Card: ___ Amex ____Visa ____Mastercard ____Discover

Credit Card Number:_____

Expiration Date:_____ CVV Number:_____

Cardholder Name:_____

Cardholder Billing Address:_____

City/State/Zip Code:_____

Patient Name:_____

I hereby agree to the above and affirm that I am a person authorized to make charges to the credit card described above.

Date:_____, 20___ _____
Cardholder or Authorized Agent