HOWARD L. BLIVAISS, D.D.S.
& Associates, P.C.
General Dentistry for the Entire Family

FINANCIAL POLICY

Thank you for selecting us as your dental care provider. Dental treatment is an excellent investment in your medical and psychological well being. We are committed to providing you with quality dental care. Payment of your bill allows us to continue to provide your treatment.

Cash patients are expected to pay in full on the day service is rendered with cash, check or credit card, unless specific arrangements are made in advance.

We accept VISA, MASTER CARD AND DISCOVER. We also provide healthcare financing through CARE CREDIT and CHASE BANK, which include no-interest and low interest plans. Please ask for additional information.

For insurance patients.

We are members of many but not all insurance plans. You are responsible for verifying that we are providers with your specific insurance plan. You should be aware of frequency limitations of procedures and non-covered benefits of your individual plan. We will happily bill most insurance companies directly. We accept assignment of benefits. If you do not wish to have your insurance pay us directly, then we require payment in full prior to the insurance claim being submitted. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from most insurance companies, you will be asked to pay the deductible, if any, and your estimated portion of the charges the day service is rendered. We estimate, as closely as possible, your coverage, but until we actually receive payment from your insurance company, it is just an estimate.

Your insurance is a contract between you, your employer (except individual plans) and the insurance company. We will assist you in dealing with the insurance company, but ultimately the responsibility lies with you. If after 60 days, your insurance company has not yet paid, we will expect you to pay us the balance due in full.

It is your responsibility to provide our office with any changes in your insurance. Improper billing may result in lack of insurance coverage. In such a case you would be responsible for payment in full.

Your insurance company may deny payment for services not covered or that they call unnecessary. You are financially responsible for all billable services.

We normally reserve your appointment time exclusively for you. Each appointment is very valuable time. We ask that you arrive at our office promptly so that you are prepared to start treatment at the appointed time. We also ask that if you need to reschedule or cancel an appointment, please contact us at least 24 hours (normal business hours of operation, Monday through Friday) in advance.

Arriving late for an appointment may result in having to wait until there is time available in the schedule that day or it may have to be rescheduled. This may result in a broken appointment fee that must be paid prior to scheduling a new appointment. No-show or cancellation of an appointment with less than 24 hours (normal business hours of operation, Monday through Friday) will also result in a broken appointment fee that must be paid prior to re-appointing.

All returned checks are subject to a $25 fee. We ask that the account be cleared within 3 business days.

Past due payments will be subject to a monthly rebilling fee of $25 and a 1.5% carrying charge. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a Collection agency or attorney, you agree to pay all fees including but not limited to attorney fees, court costs and collection agency fees.

Please request in writing if you wish to have your records transferred to another dentist (other than a referral). The fee for duplicating records (as required by state law) is based on the volume of the records and is payable prior to the duplicating and sending of the records.

I have read and understood the above information. I agree to all the above policies. I acknowledge that I am fully responsible for all charges incurred for services rendered by HOWARD L BLIVAISS DDS AND ASSOCIATES, PC.

I authorize release of any information including diagnostic and treatment records and diagnosis of any treatment required to any health care professional deemed necessary for my treatment, as well as to my insurance company or companies in order to comply with applicable laws and facilitate the billing and reimbursement for the treatment provided.

Peterson Executive Center • 3500 West Peterson Avenue • Suite 200 • Chicago, IL 60659 • Tel 773-509-1234 • Fax 773-509-0495

HOWARD L BLIVAISS DDS AND ASSOCIATES, PC

FINANCIAL POLICY

Patient ______________________________________

Financially responsible person ______________________________________

Signature ______________________________________

Date ____________________

This covers the following patient dependents:

If a third party, not residing with the patient, is responsible for the account balance and the third party defaults on payments, the person named below will take full responsibility for the balance of the account.

Person accepting responsibility ______________________________

Date ____________________