# NEW LENOX DENTAL GROUP

**1600 W Lincoln Highway**
**New Lenox, IL 60451**
**(815) 485-2345**


## OUR OFFICE POLICY

**Regarding Insurance:**
The full fee for dental services is your responsibility. Please understand that your insurance policy is a contract between you and your insurance company. We are not part of that contract. As a courtesy, we will contact your carrier and get verification, benefit information, and submit your claim electronically when possible. However, if your insurance company decides not to pay, you will be responsible for the completion of payment. Please be certain to provide us with current and complete information.

**Usual and Customary Rates:**
Our dental practice charges what is usual and customary for our service area. You are responsible for payment regardless of any insurance company's arbitrary determination of rates.

**Prior Approval and Pre-Estimates:**
Sometimes insurance companies will give prior approval for treatment and then deny payment when a claim is submitted. We will do our best to defend the claim in this case. However, if the company decides not to pay, the responsibility is yours and the fees will be your responsibility.

**Unpaid Balances:**
All balances if left unpaid after 90 days will be subject to finance charges as well as collection agency fees, attorney fees, and court costs incurred. Checks, which are declared non-sufficient funds, will be charged a $25.00 service fee.

**Minor Patients:**
The adult accompanying a minor is responsible for full payment of the fee charged. If the minor is covered by another parent's insurance that is not present, authorization must be given to us by the policy holder.

**Missed Appointments:**
It is our policy to charge for missed appointments, unless rescheduled at least 24 hours in advance, at the rate of $35.00 per visit. Please be considerate by keeping scheduled appointments or by calling in advance as soon as you know there will be a conflict.

**PLEASE NOTE, WHETHER YOU HAVE INSURANCE OR NOT, YOUR ESTIMATED PORTION IS DUE AT THE TIME OF THE SERVICE. ON ALL MAJOR SERVICES (CROWNS, DENTURES, PARTIALS, ECT…) THE ESTIMATED PATIENT PORTION OF PAYMENT IS DUE ON THE DATE OF FINAL DELIVERY.**

I have read and hereby agree to the above terms and conditions:

_____ Date: _____
Signature of patient or responsible party