1314 Eagle Ridge Drive
Schererville, IN 46375
219-865-4095

Office Financial Policy

Payment
Payment is due at the time of service. We accept cash, personal checks, debit cards, most major credit cards, and Care Credit. We also offer interest-free financing (PaySafe) for 6-18 months depending on the amount financed. There will be a $30 fee assessed for returned checks. _____

Insurance
Insurance benefits are determined by your employer and not your dentist. Having dental insurance is not a guarantee of coverage. Dental insurance will not cover all costs associated with your treatment and nearly all plans have a maximum dollar amount allowable per year. (Think of it as a gift card that you can apply towards your dental care). You are responsible for any balance not covered by your dental insurance. Any deductible or estimated co-payment amount will be due at the time of treatment. You will be expected to pay for all services rendered if we are unable to verify your coverage prior to treatment. We are happy to submit all claims on your behalf to your dental insurance. You are responsible for providing our office with your most up-to-date insurance card. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. _____

Cancelled Appointments
Your appointment time is reserved exclusively for you. If you are unable to keep your scheduled appointment, please call our office at least 24 hours prior to your appointment time. We reserve the right to charge a $50 no call/no show fee. This fee must be paid prior to the start of your next appointment, otherwise all remaining appointments may be cancelled. _____

Past Due Accounts
Patients with a balance of $100.00 or more will require payment in full prior to being seen again. Past due accounts will ultimately be turned over to collections. If we turn your account over to collections you will be responsible for any costs associated with the collections including, but not limited to, reasonable attorney fees. Accounts placed in collections status may lead to the termination of our doctor/patient relationship.
We make every effort to resolve balances prior to sending them to collections. If you have a question about a bill or difficulty in paying your balance, please call our office to discuss your bill or to set up a formal payment plan. _____

I have read, understand, and agree to the above policy. I agree to assume financial responsibility for services provided.

_____ _____
Patient Signature or Authorized Representative Date

_____
Print Name / Relationship to Patient