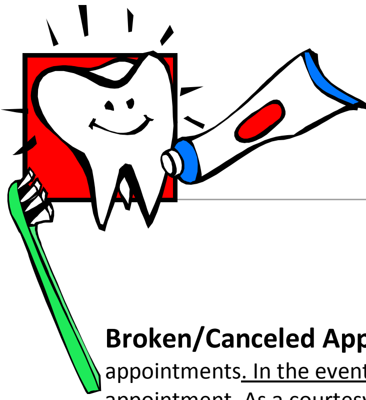


Family Dental of Lincoln

5206 N Lincoln Ave Chicago, IL 60625

Ph: 773.561.5106 Fax: 773.561.5517

OFFICE POLICIES

Broken/Canceled Appointments: We are very appreciative of patients who arrive on time for their scheduled appointments. In the event you need to cancel an appointment, we request notice at least 24 hours in advance of the appointment. As a courtesy, our office may contact you via email or phone to remind you of the appointment(s). While certain emergencies and other issues may be taken into consideration, Family Dental of Lincoln **reserves the right to apply a fee of $25 per half-hour of the scheduled appointment for failure to provide adequate notice.**

Guarantee of Payment/Assignment of Insurance Benefits: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service. I authorize payment for services rendered to me to be made directly to this office for benefits otherwise payable to me. These payments shall not exceed the regular charges for this period of treatment. **I also understand that I am responsible to pay any charges not covered through my insurance benefits, including but not limited to non-covered services, applicable deductible and/or co- insurances as defined by my policy (ies) or, any fees for services in the event that I do not have insurance coverage.**

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Family Dental to incur lab, equipment and labor costs up front. **In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of the treatment.**

Past Due Balances & Collection Services: Family Dental makes an effort to provide all patients with education and information regarding proposed and completed treatment as well as the costs associated, in order for each patient to make an informed decision regarding their treatment. Family Dental of Lincoln also participates in lending programs to extend interest-free credit to qualified applicants for certain procedure. However**, in the event that I do not pay outstanding balance(s), I understand that 12% interest rate will be applied to any past due balances on my account(s)**. I also understand that should my past due balance be referred to an attorney or collection agency, I will be financially responsible for any additional costs incurred such as attorney fees, collection agency fees, court costs, etc.

Patient Dismissal: Our practice takes pride in our dentistry and in the relationships with our patients who believe in quality care. Cooperation is a key element to successful treatment. Family Dental of Lincoln reserves the right to dismiss patients in the interest of customer service and quality care for all patients. Family dental of Lincoln will be happy to transfer patient records to another provider at the request and approval for any patients who are dismissed.

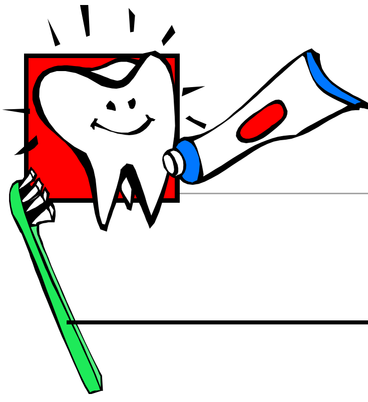
I agree to abide by the policies listed above. I understand that if I have any questions about these policies, I may request assistance and further explanation at any time from a Family Dental of Lincoln staff member.

____ ________________________

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

____ ________________________

Family Dental of Lincoln STAFF WITNESS DATE



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________________________ have received a copy of Family Dental of Lincoln's Notice of Privacy Practices.

Alternate Communications Information

Family Dental normally contacts patients using phone or email for appointment reminders, account information, pre-medication information, and other information pertaining to your treatment or account.

If you will need Family Dental of Lincoln to observe alternate methods to contact you other than what you have listed, please list them below, otherwise, leave this section blank:

___ Phone: (Number)_________________________ May we leave a message? ___Yes ___ No

May we leave a message regarding pre-medication if necessary? ___Yes ____ No

___Mail: (Address) ____

___Other: (Please List) ____

When leaving a message, please list your preference for how Family Dental of Lincoln identifies itself:

___ Family Dental of Lincoln ____Dentist's Office ___ None ____ Other: ________________

_________________________________ _____________________________

PATIENT/GUARDIAN SIGNATURE **DATE**

FOR OFFICE USE ONLY

____________________________________ _______________________________

STAFF WITNESS **DATE**

We attemted to obtain written acknowledgement of receipt of our Notice of Practice, but acknowledgement could not be obtained because:

___ Individual refusal to sign
___ Communications barrier prohibited the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)