Chinwalla Periodontics Implants

One Tiffany Point, Suite 205
Bloomingdale, IL 60108
630.582.3120 • Fax 630.582.3137

Juzer Chinwalla D.D.S., M.S.D.
Diplomate, American Academy of Periodontology

8342 Lemont Rd., Suite F-3
Darien, IL 60561
630.985.1995 • Fax 630.985.1971

OFFICE POLICY & FINANCIAL TERMS

Understanding the specific requirements of your insurance plan can be difficult. The following information is designed to help answer any questions you may have regarding your insurance coverage and the payment policies of our office.

The fee of your first office visit / examination will be $175.00

IF YOU DO NOT HAVE INSURANCE: We ask that you pay for your office visit at the time of your appointment.

IF YOU HAVE PRIVATE INSURANCE: Please give your insurance card and any necessary claim forms to our Patient Scheduling Coordinator during your appointment. As a convenience to you, we will complete the forms and submit them directly to your insurance company. (If this is the selection you make below). You may be required to make a payment (co-payment, partial payment, deductible, etc.) for your visit today. We will make every effort to have that information available to you by the time you complete your exam.

IF YOU BELONG TO HEALTH MAINTENANCE ORGANIZATIONS (HMOS): If we are affiliated with your HMO, please show us your HMO membership card and your referral letter from your primary care dentist authorizing your appointment at out office. AS long as you have your referral letter with you, you will only be charged the co-pay as required by your dental plan for your visit. If we are not affiliated with your HMO or you do not receive authorization for your appointment from your primary care dentist, you will be responsible for the cost of your appointment. We ask that you pay this fee at the time of your visit.

FEES: We share your concern about the increasing costs of dental care. Because statements and billing fees have become so expensive and in an effort to keep your dental costs down, we ask that you pay for your first office visit and your estimated co-payment for the other procedures at the time the service is rendered. Our fees are usual and customary for this area. Fees for surgery include follow-up care, but do not include x-rays. We will be happy to discuss fees with you, and an estimate of fees for any periodontal procedure(s) will be given when requested.

INSURANCE: We remind you that the responsibility rests with the patient being treated or parent / guardian. For office visits we expect payment at the time of the office visit by cash, check or credit card (MasterCard or Visa). We remind you that most insurance contracts involve deductibles and / or percentage allowances with the result that the entire bill is seldom covered in full. Should we receive any payment which exceeds your balance due, the excess will be promptly refunded to you. We know questions can arise on insurance matters and these should be discussed with our front desk staff. We will be happy to help you receive the maximum benefits; however, the agreement of the insurance company to pay for dental care is a contract between you and the company. Feel free to address any questions regarding your bill to our office at (630) 582-3120 during regular business hours.

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OFFICE POLICY & FINANCIAL TERMS *(CONTINUED)*

CANCELLATIONS: We require at least 48 hours notice to change your appointment; otherwise there will be a $60.00 charge.

PAYMENT: Payment is expected when services are rendered.

LATE & FINANCE CHARGES: A $25.00 late payment (or no payment) charge may be applied to accounts that are late or no payment is made. A 1.5% finance charge will be added per month to all overdue accounts.

DELINQUENCY: If your account falls into delinquency, you agree to pay any and all collection agency charges, attorney fees and court fees.

We offer to bill your insurance company as a courtesy to you. However, your co-pay must be paid at the time of your appointment, when the periodontal procedure is completed. Your estimated co-pay will be approximately 40% of the treatment fee. You have the following three (3) options: (Please select one option by placing your initials in ONE of the three selections below, thank you).

☐ We will send out a Pre-treatment Estimate to your insurance company for approval. When we receive the estimate from your insurance company, you will be responsible for amounts they do not cover at the time of your procedure(s).

☐ You pay an estimated co-pay at the time of your visit and we will bill your insurance company for the procedures performed. You may have a balance after the insurance benefits are received. If you have a balance due, we will bill you for the difference, that payment will be due upon receipt of our bill. If you have a credit due from us, we will send you a check for the overpayment immediately. Or, if you wish we may apply the credit to any future services.

☐ You may pay the entire balance and bill your insurance company yourself.

Date: _____ Name (printed): _____

Name (Signature): _____