APPLE DENTAL P.C.

1120 N. MAIN STREET, SUITE # 2
GLENDALE HEIGHTS, IL – 60139
TEL: (630) 545 1500; FAX: (630) 545 1511
WWW.APPLEDENTALPC.COM

OFFICE POLICIES

PATIENT PRIVACY: Our NOTICE OF PRIVACY PRACTICES details how we may use and disclose your protected health information. You have the right to review and request explanation of the terms prior to signing the form and a copy will be provided to you. Our office will communicate via phone directly to you for appointments or any necessary medical and dental information including x-rays and other test results, if unable to reach you directly, your signature gives us consent to communicate via answering machine, voicemail, electronic communication via fax, email or through another person and you agree to absolve APPLE DENTAL P.C. and their staff of any liability should that information be received in error by a third party. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your previous consent. If there are any changes to the terms of the policies, we will post updated copies in the clinic. You have the right to refuse to consent / sign the privacy information.

CANCELLATION POLICY: Scheduled appointments are reserved specifically for you, therefore, when sufficient notice is not given when you cancel or reschedule an appointment, it does not give us enough time to contact another patient on our waiting list who would benefit from coming in earlier. If a cancellation is unavoidable, please call the office as soon as possible, better if 24 hours in advance so that we may offer that time to another patient. We understand that rare emergency situations may occur and these circumstances we do understand. However, if two cancelled / missed appointments occur without 24 hour notice, our office reserves the right *NOT* to schedule any subsequent appointments and a charge may be added to your account upon the discretion of our office.

DISMISSAL POLICY: Prescription drug abuse, abusive behavior, non – payment of dues and any other serious issue as determined by this office will lead to dismissal from our dental practice.

FINANCIAL POLICY: Payments / co - payments for dental service are due at the time of service. Every effort will be made to provide a treatment plan for services with estimated costs so that you are aware of dues at subsequent visits. As a courtesy to our patients, we submit claims to dental insurance claims company (if applicable) for the treatment. Please be advised that on most occasions the insurance companies only a pay a portion of entire bill. However in the event the insurance company *DOES NOT PAY* the estimated portion of the billed amount, the patient / guardian will ultimately be responsible for all costs associated with the offered services.

We greatly appreciate payment in full prior to completion of case. Please make prior arrangements with our office for any financing options. *For your convenience, we accept cash, check, credit cards and offer financing options including CARE CREDIT (third party financing).* We may charge @ 18% interest per annum for outstanding bills.

We will charge a $25.00 fee for any returned / bounced checks, and may pursue civil / criminal actions with appropriate local law authorities. For all non paid dues additional interests including attorney or collection costs will be applied towards patient balance.

RELEASE OF RECORDS: A written request is required for transfer / release of records and any pending balance on the account must be paid in full. Please allow 7 – 10 business days to complete your request. Any records or radiographs 10 years and older may be destroyed for inactive patients per State Regulations.

I have read and agree to the office policies.

---------- --------/--------/---------

Patient / Guardian signature Date