GLEN ELLYN
IMPLANT & ORAL SURGERY CENTER
CHAD DROUIN, D.M.D.
493 Duane Street, Suite 301 • Glen Ellyn, Illinois 60137 • (630) 858-5755 • Fax (630) 858-5760

Financial Policy and Agreement

Thank you for choosing Glen Ellyn Implant and Oral Surgery Center for your oral surgery care. We are committed to providing the best care for our patients and making your experience a positive one in every way we can.

Payment Policy: We ask that you read through the financial policy and sign at the bottom prior to treatment. Payment is due at the time of service unless prior arrangements have been made with our office. We accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

There is a $30.00 fee charged for check returned due to insufficient funds.

Regarding Insurance: We accept all insurance policies *(with the exception of any medical HMO or dental DMO),* however, **we are only "in-network" with Delta Dental of Illinois PPO Premier. We are "out-of-network" with all other medical and dental insurance plans**. We would be happy to contact your insurance company regarding benefits to determine a reasonable **estimate** of your out of pocket expenses for services rendered by us. Please remember this is just an **estimate** and your benefits could change after claims are submitted to your insurance company. The remaining balance will be **your responsibility**. You may have benefits for your treatment through your dental and/or medical insurance plans. Similarly, you may not have any coverage under either of these plans for your specific treatment plans. We will submit to your insurance plans as a courtesy to you. Please understand that your insurance policy is a contract between you and the insurance company, we are not a party to that contract. You are responsible for paying your bill, not your insurance company.

Service Charges: A $10.00 monthly service charge will be placed on the account to balances that are unpaid 30 days after receipt of insurance payments or notification of payment denials.

Please let us know if you have any questions regarding our Financial Policy.

I agree to pay my bill in full within 90 days of treatment regardless of the status and amount of the insurance company payment. I understand that I am responsible for the entire treatment balance regardless of insurance coverage. **I have read the Financial Policy and I understand and agree to this Financial Policy as it is written.**

Patient Name:_____ **Date:**_____

X_____ _____

Signature of person financially responsible **Print full name of person financially responsible**