ROSEMONT DENTAL CENTER
MARTY M. ASKARI D.M.D.P.C.

Our commitment is to provide the best quality dental care to the entire family through exceptional services and the utilization of advanced technology.

METHODS OF PAYMENT

1 - Cash or credit card (Visa, MasterCard, American Express)
2 - Dental insurance described below

A - We are pleased that you have dental insurance and our office will assist you in obtaining the maximum benefit specified in your contract. However, your insurance contract is between you, your employer and the insurance company. We will need you to bring us a copy of your insurance card so that we can call to verify your coverage.

B - As a courtesy to you we will file your insurance and accept assignment of benefits. If you have signed the insurance payment authorization form we require that your co-payment be paid at the time of service.

C - The Insurance Company does not cover all procedures. Some insurance companies arbitrarily select certain services that they will cover. Any service not covered by your insurance is the patient's responsibility.

RELATED INFORMATION

1 - Returned checks and balances older than 60 days may be subject to additional collection fee of 1.5%. These additional fees will be applied to the unpaid balance at the end of the month. There will be a $35.00 fee for all returned checks.

2 - In the event that the account is not paid and we refer the outstanding balance to the collection agency, you will be responsible for all the fees incurred for the collection of your bill (i.e. attorney fees, court cost and collection agency fees)

3 - Your appointment time has been reserved for you. Any change in your appointment affects many patients. A 48-hour notice is required in order to reschedule or cancel your appointment. If we do not receive a 48- hour notice there will be a fee of $50.00 charge to your account.

I have read and understood the above information. I realize that I am responsible (regardless of my insurance) for any charge(s) incurred from services rendered.

NAME (PLEASE PRINT) _____

IF MINOR PLEASE PRINT NAME _____

SIGNATURE _____ DATE _____