Dr. Dennis P. Kent D.D.S. Ltd.,
(708)354-0585
(708)354-0879 fax

Financial Policy

1415 W. 47th Street
LaGrange, IL 60525

Please initialize each paragraph

Insurance: As a courtesy to all our patients we will verify your dental insurance benefits, but you are responsible to know your Plan Coverage, exclusions and limitations. The estimated amount not covered by your insurance is due at the time of treatment and may be paid in cash, personal check, Visa, MasterCard or Discover. To help you accept an extensive treatment plan, we now offer Carecredit, which is treatment Financing Program. We no longer offer in-house payment plans.
All Estimates are subject to final approval by your dental insurance plan; therefore the amount due is subject to change after final explanation of benefits have been paid. _____ **(initialize)**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Most insurance companies have a deductable that must be met before the company will pay their portion. If you have not met your deductable for the year, you are responsible for any charges until the deductable is met. Dr. Kent is not in network with any insurance company. Even after the deductable is met, most insurance companies will only pay out-of-network providers 50-80%. You will be responsible for the rest.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Our office will no longer submit to secondary insurances. After your primary insurance has paid and you have paid the balance; we will give you all the forms needed to send to your secondary insurance company.

No Insurance: Patient balances are due immediately and are not contingent upon receiving a statement. Upon completion of services, the balance must be paid in full. Our office will help you apply for Carecredit for any extensive treatment you wish to have. _____ **(initialize)**

Should you fail to pay unpaid charges for more than 30 days, you will be asked to provide a credit card for the balance. Unpaid charges over 60 days will incur a monthly service fee of $10. Accounts with no activity for 60 days may be forwarded for further collection action. If your account defaults and is referred to a collection agency or attorney, you will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. _____ **(initialize)**

If you have any questions about the above information, or and uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us, we are here to help you.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM THE SERVICES RENDERED BY DR. DENNIS P. KENT.

PRINT NAME_____

SIGNATURE_____ **DATE**_____