Dr. Susan Klyber DDS, PC

Dentistry For The Family
6725 Stanley Avenue, Suite 6
Berwyn, IL 60402

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Office Policy and Financial Terms

Effective June 1, 2017

Achieving your best oral health means that you are informed about your dental treatment including understanding the financial part of your care. In an effort to keep dental treatment affordable while maintaining the highest-level of professional care you deserve, we've established the following financial terms and policies. Please read them carefully. If you have any questions, contact our office so we can discuss them with you. Thank you for being our patient and entrusting us with your dental care!

This is an agreement between Susan Klyber DDS, PC and you. By signing this agreement, you consent to treatment by Dr. Susan Klyber and her staff and agree to pay for all services that are received and you agree to all the terms and conditions contained in this agreement.

Terms & Conditions:

Payment:

We accept VISA, MasterCard, Discover, American Express, cash, and checks. Payment is due at the time of treatment unless we approve other arrangements **PRIOR** to initiating treatment. If you need alternate payment plans, please discuss your need with our Patient Scheduling Coordinator. We have payment options available and approved through third-party financing (CareCredit).

Cancellations:

Should you need to cancel or change your appointment, we require at least 2 business days advance notice. Otherwise, you will be charged $75.00 for a missed appointment.

Regarding Your Dental Care and Your Insurance:

Our goal is providing you with affordable best-option preventive, restorative, and cosmetic dental care. **We determine your treatment plan based on what will be dentally best for your health, not on what your insurance company pays or doesn't pay.**

Your dental insurance plan is a financial contract between you, your employer and your insurance company that helps you pay for your dental care. Our office does not determine your dental policy benefits. Your benefits are determined by your insurance company and what your employer is willing to pay for your dental coverage as a benefit of your employment.

When we provide you with dental services, we don't assume that the insurance company will pay us in full. You are ultimately responsible for any balance on your account that your insurance does not pay. No insurance plan covers all dental procedures. Depending on your dental policy benefits, you are likely to incur out-of-pocket co-payments, deductibles, and non-covered dental procedures.

If you have dental insurance:

- When you arrive for your appointment, please present your insurance card and/or any additional information to our Patient Scheduling Coordinator so we can update your records
- As a convenience to you, we will complete your **primary insurance forms** and submit them directly to your insurance company.
- As of **January 1, 2016, we will no longer process** any secondary insurance.
- In the event that your insurance company has not made payment within 60 days of filing your claim, the balance will become due in full on your account.

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Terms & Conditions: *continued...*

If you have dental insurance: *continued...*

- You can request "Estimated Fees" for any required treatment plan. Estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment. We will do all we can to make sure your estimate is accurate and assist you in receiving your maximum allowable benefits.
- We will process any requests from your insurance company that may assist payment of your claim. We will not enter into a dispute with your insurance company over any claim.
- Should there be an overpayment on your account, it will be refunded to you.
- If your account balance is overdue, then elective dental work will be delayed until the balance is paid.

If you have DO NOT have dental insurance:

We require fees for services provided are paid in full on the day of service unless other arrangements have been made. If several visits are required, then 50% is due at the start of your procedure and the remainder is due by the completion of the procedure.

Statements, Fees, and Charges:

- Payments on your account are due within 30 days of receiving your statement. **A $25.00 charge will be applied to accounts that are past due.**
- **Returned checks will be charged $40.00** (subject to change as bank fees increase) and added to your account. Before we accept another check, the returned check fee must be paid in cash or credit card.
- You may, at anytime, request a copy of your records. This request may be subject to a normal duplication fee to cover this service.
- A finance charge, 1.5% per month (18% APR), will be assessed on all overdue accounts which are outstanding for 60 days or more.
- If your account is 120 days or more past due, you will be responsible for all collection agency charges, attorney fees, and court costs.

Credit History, Waiver of Confidentiality, and Divorce:

- In the event that your account becomes 90 days past-due, we have the option to report your account status to any credit reporting agency such as a credit bureau.
- You understand that if your account is submitted to an attorney or collection agency, or if we have to litigate, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.
- In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS AS STATED ON PAGES 1 AND 2. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DR. KLYBER.

Patient's Name: _____ **Responsible Party:** _____
(If patient is under 18 years old)

Signature: _____ **Date:** _____