Office Policy

Thank you for choosing our office to provide your dental care. At North Aurora Smiles, our goal is to establish long term relationships with our patients by providing the highest quality dental care in the most empathetic and gentle manner, in a comfortable environment. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you we ask that you take a moment to read and sign this office policy.

Our doctors take great pride in providing the highest level of dental care. Please keep in mind that our doctors are treating You, our patient, and not the insurance company, and thus make their treatment recommendations based on what is best for your oral health and not simply what is covered and not covered by insurance. We do make every effort to maximize your dental insurance benefits.

The information contained in our treatment plans is an estimate of your deductible, the portion covered by your insurance, and co-pay. It is only an estimate and not a guarantee of payment from the insurance company. Our estimates may be different than the dental insurance calculations, therefore, the amount due to our office may need to be adjusted accordingly. A patient's eligibility and benefits can only be determined at the time the claim is processed. Some insurance companies may pay less for tooth colored fillings (composites), crowns, bridges, and other services. The patient/guardian should refer to their benefit booklet complete dental coverage details. It is ultimately the patient/guardian's responsibility to be aware of their insurance plan coverages and limitations. Any insurance claim remaining unpaid after 60 days will automatically become the responsibility of the patient/guardian.

Payment of co-pay/deductible is expected at the time of service. We accept cash, checks, and all major credit cards. All treatment rendered is ultimately the responsibility of the patient/guardian regardless of insurance coverage. Should the fees for the professional services not be paid by 90 days, with the exception of pre-approved payment plans, the office reserves the right to turn the account over to a collection agency. A 50% collection fee, reasonable attorney fees, plus applicable finance charges, disbursements, allowances, and costs provided by law shall be included in the computation of the amount due.

I understand and agree if I miss any scheduled appointment without providing at least 48 hours' notice, except in extenuating circumstances as determined by this dental office, I can be charged a "no show" fee of $35 per half hour that I was scheduled. This would be no different than if I failed to show up to a reserved hotel or airplane flight. I understand that this will not be able to compensate the doctor or his staff fully for their time and I agree that the charge is fair and reasonable. If you would like a copy of your dental records, there is a $25 per person duplication fee.

Please notify the front desk staff if there have been any changes to your dental insurance since the last time you were in. There will be a $25 administrative fee applied to your account if we do not receive your updated insurance information. This fee covers the extra time and resources spent to correct your account and resubmit any pending claims.

By signing below, I signify that I have read, understand, and agree to each paragraph and provision of this financial agreement.

Patient Name _____ Date of Birth: _____

Signature_____Date_____
(Patient/Parent/Guardian)