



Patient Care Cancellation and Financial Agreement

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by *SE Chicago Dentistry* and understand that payment is due at the time of service unless prohibited by an existing contract between *SE Chicago Dentistry* and your insurance company. For procedures that are billed to my insurance I understand that I become personally responsible for the charges in the event that my insurance company does not provide payment within 60 days and have provided a credit card listed below to cover these charges.

I understand that my insurance company *may not* cover all necessary balances and may send the check to the wrong party. In the event that the insurance company mistakenly sends a reimbursement check to me for services that were rendered but not previously paid for I will endorse the check to *Stone Dental Group* within 5 business days of the said payment; I hereby authorize the outstanding balance to be charged to the credit card listed below. If my insurance company reimburses *SE Chicago Dentistry* for services that I paid for at the time of service or prepaid, I understand *SE Chicago Dentistry* will reimburse the credit card listed below that day the payment is received. In those instances in which an insurance company has made a partial payment for services, I authorize *SE Chicago Dentistry* to collect outstanding balances including, co-pays, co-insurance, deductibles, and non-covered services on my credit card listed below.

I understand that *SE Chicago Dentistry* requires a 24-hour notice to cancel or reschedule an appointment and failure to provide such notice will result in a \$50 non-refundable deposit towards any future appointments.

If I prefer to have appointments that are 2 hours or more I agree to provide a non-refundable deposit of 50% of the services to be provided.

If the following credit card number or payment by check is invalid or does not accept charges, I authorize you to \$25 rebilling fee on the credit card listed below.

Name: _____

Credit Card Number: _____

Expiration Date: _____ Security Code (located on the back of the card): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

_____ I would prefer to have statements mailed to me before charging my credit card so that I *Initials* can have the opportunity to pay by check. However I understand that if payment is not received within 30 days of the statement date, that balance will be charged to the credit card listed above, including a \$25 late payment charge.

2800 N Sheridan Rd Suite 410 Chicago, IL 60657
233 E. Erie Suite 406, Chicago, IL 60611

P: (773)880-5080 F: (773)880-5084
P: (312)587-0200 F: (312)587-0223