845 N. MICHIGAN AVE., SUITE 955W, CHICAGO, IL 60611 | (312) 654-1220 | watertowerdental.com

FINANCIAL POLICY

Your clear understanding of our Financial Policy is important to our professional relationship.

APPOINTMENTS

A time has been reserved for you. Please arrive 10 minutes before your appointment to verify and/or update your insurance and other information. Patients arriving 10 minutes or more after their appointment may need to be rescheduled.

CANCELLATIONS – PLEASE CANCEL AT LEAST 24 HOURS IN ADVANCE TO AVOID CANCELLATION CHARGES

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance.
Please call or text the office at (312) 654-1220. or email us at wtdental@gmail.com.

Cancellation Fees (24 hours or less):

- Appointments up to one hour: $75.00
- Appointments over 60 minutes: $75.00 per scheduled hour

PAYMENT FOR SERVICES

We are committed to providing the best quality of care at reasonable fees. For our practice to maintain this, we request the following:

- A valid credit card along with your insurance information on file with our office. Patients are responsible to notify us if their credit card or insurance information changes.
- For patients with dental insurance; payment of all deductibles is required at the time of service. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.
- For patients with an insurance reimbursement sent directly to them, full payment is due at the time of service.
- For patients who do not have insurance, full payment is due at the time of service.
- For comprehensive treatment plans, payment is expected at the time of each appointment unless a payment plan is in place.
- Any remaining balances and unpaid insurance claims of 60 days or more will be charged to your credit card on file. We will notify you, via email, and attach a copy of your receipt. If insurance reimbursement is received at a later date, a credit will be issued to your card and we will notify you via email.
- The insured is responsible for any charges not covered by insurance.
- If your treatment requires multiple visits (i.e. crowns, implant restorations, veneers, bridges, partials or dentures, etc.), your balance for the estimated patient portions will be due on the first day of treatment. Payment arrangements can be made prior to the start of treatment with our practice manager. Any remaining balance will be processed through your credit card on file.
- If you need to discuss a payment plan, please speak with us prior to scheduling your care plan appointments. A payment plan will be billed to your credit card monthly until the balance is paid in full. Prior to scheduling new appointments, previous outstanding balances need to be paid.
- All checks returned due to non-sufficient funds (NSF) will be subject to a fee of $35.00 for each return. The outstanding balance along with the $35 fee will be charged to your credit card on file.
- For your convenience we accept: CASH, CHECK, ZELLE, APPLE PAY, GOOGLE PAY, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER.

In addition to the principal amount owed, I also agree to pay 30% of the unpaid balance if my account is turned over to a collection agency or attorney in an effect to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collection agency fees and attorney fees.

INSURANCE

As a courtesy to you, WaterTower Dental, Ltd, will process your insurance claims. We are an out-of-network (non-participating) practice which may affect your benefits. The claims we submit to insurance companies indicate that you have assigned those benefits to our practice. We can submit a pre-estimate to your insurance to assist you in planning a comprehensive treatment plan.

Most insurance companies have an annual limit for the amount they will reimburse for dental services per calendar year. If, under your plan, you or your household exceeds your policy's annual limits, you are responsible for the full remaining balance. Please monitor your annual benefits. WaterTower Dental, Ltd., staff cannot provide information on your remaining benefits. If you have coverage questions, please contact your insurer.

We cannot legally become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

COLLECTIONS

In addition to the principal amount owed, I agree to pay an additional 35% of the unpaid balance if my account is turned over to a collection agency or attorney to collect any outstanding balance. Additional fees and charges may include but are not limited to the following: filing fees, court costs, collection agency fees and attorney fees.

Financial and Cancellation Policy Acknowledgement

A credit card is required to be kept on file for any incidental charges not paid by your insurance company. Patients will receive an email receipt for any amount that is charged to their credit card.

Patient Authorization:

I authorize payment of my dental benefits, to be sent directly by WaterTower Dental, Ltd. If the claim is outstanding after 60 days, I will be notified that the full balance has been charged to my credit card. If payment from the insurance company is received at a later date by WaterTower Dental Ltd., a credit will be issued to my credit card for the amount received.

I have read, understood, and agreed to the financial and cancellation policy. I understand that I am fully responsible for the fees for service rendered, regardless of any insurance that I may have. A scan of your credit card will be taken and added to my file.

CREDIT CARD INFORMATION

Name of patient: ____

Name of cardholder: ____

LAST FIRST MI

Card Type: M/C Visa Amex Discover Expiration date: _________ CVV#: _________

Credit Card Number: ____ Is this an HSA Card? Yes No

Billing Address: ____

I hereby acknowledge receipt of services, authorize Water Tower Dental, Ltd., to bill the credit card I have provided above to keep on file for such services, and agree to take all further actions to pay the charges in full and to perform the obligation set forth in agreement with my credit card issuer.

Authorized Signature: _____________________________________ Date ______________________

PATIENT OR GUARDIAN SIGNATURE

Responsible Party's Signature: ___________________________ Relationship to Patient: _______________