Unique Smiles of McHenry
4101 W Shamrock Lane, McHenry, IL 60050
(815) 385-0777
usmilesofmchenry.com/

OFFICE POLICIES FORM
| DOB:

Our goal is to provide the highest quality of dental care possible and to clearly communicate our financial policy.

I agree to be responsible for payment of all services rendered to myself and my dependents. I understand payment is due at the time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through the use of my Social Security number and any other information given.

I understand that there is a $25.00 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35.00 processing charge for insufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment, it will be turned over to an outside collection attorney. I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in order to collect payment due.

As a courtesy to me, I understand this office will file any dental insurance claims on my behalf. I hereby authorize release of all information needed for such claims and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, I agree to pay the full remaining balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine, and I am obligated and agree to pay the full remaining balance.

Cancellation Policy:

Patients arriving more than 10 minutes late for an appointment may need to be rescheduled.

During Office Hours: Appointments must be rescheduled or canceled within 24 hours of scheduled appointment time to avoid a cancellation charge of $50.00.

After Office Hours: Appointment cancellation made on voicemail or email (NO TEXT) must be made within 48 hours to avoid a cancellation charge of $50.00.

By signing this, I acknowledge the above conditions of treatment and payment and agree to these terms.

Patient's signature: Date: