Professional Center of Dental Care
433 N. Bolingbrook Drive Suite 1
Bolingbrook, IL 60440
630-759-4191

Dear Patient,

Welcome to our office and thank you for selecting our staff as your dental health team. It is the policy of this office to render the highest quality, preventive oriented dentistry available today. Our staff consists of general dentists, hygienists and an orthodontist. We have employed these professionals with the intention that most of your dental needs may be met in this single office setting. We will do our best to alleviate your dental fears and make your visit as comfortable as possible.

Patients are seen on an appointment basis. The appointment you schedule is **reserved strictly for you.** When it becomes necessary for you to change or cancel an appointment, it is expected that at least 24-hour notice be given to this office. Failing to comply with this request or failure to show up for a scheduled appointment, will result in a charge of $50.00 for a hygiene appointment and $75.00 for a doctor appointment. Dental insurance will not pay for missed appointment charge. Emergency appointments will be scheduled as soon as possible.

I understand it is **my responsibility** to know the terms and conditions of my insurance policy including coverage, deductibles, and any limitations and frequencies of procedures.

Payment is expected at the time services are rendered. For those patients who have dental insurance, we will assist you in processing your dental claim, but we do request a partial payment at the time of treatment as no dental insurance pays 100% of all dental treatment. We would appreciate your cooperation in these matters.
If in the event the outstanding balance goes unpaid and we are forced to use an outside collection agency and/or an attorney, it is understood and agreed to that up to 30% of the balance due will be added as collection and/or attorneys' fees. If in the event we are forced to file suit to collect the outstanding balance, it is understood and agreed to that you will be liable for all court costs spent whether judgement has been entered or not.

We will need to make a copy of your driver's license or state identification card to prevent fraud and/or identity theft.

Your dental health is our main concern, if you have any questions regarding dental treatment or financial questions, please do not hesitate to speak to any staff member.

AUTHORIZATION

I hereby authorize payment of dental benefits, otherwise payable to me, to the Professional Center of Dental Care. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient Name: ____

Signature of patient or responsible party if patient is a minor:

____ Date ___/___/___