Dr. Yoonju Kim / Delight Dental Studio
1651 N. Western Ave. Ste. B&C
Chicago, IL 60647

TEL) 773-698-8752
FAX) 773-830-7107
www.delightdentalstudio.com
info@delightdentalstudio.com

Thank you for choosing our office for your dental needs. We are committed to your treatment being successful and satisfactory. Please understand that payment of your account is considered a part of your treatment. It is important that your account be handled properly in order to keep charges as low as possible. Your cooperation in this is appreciated.

Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

FINANCIAL AGREEMENT

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, Visa, MasterCard, American Express and/or Discover. We also offer CARECREDIT, which is a financing option that is available only for healthcare expenses.

There will be a fee for any additional procedure NOT included in the original treatment plan.

APPOINTMENTS

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hour notice for any cancelled appointment. After 3 missed appointments or cancelled appointments without 24 hour notice we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

INSURANCE

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January – December) and your input on if your dental insurance benefit has been used in another offices.

All of our doctors will diagnose treatment based on your dental health not your insurance coverage.

You must realize that :

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured has a better ability to deal with the insurance company and the employer responsible for the policy.

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

* If sent to collections, I agree to pay all related fees and court costs.

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

* I will pay a fee of $25 for appointments broken without 24 hours notice.

* Treatment plans may change, and I will be responsible for the work actually done.

* Any treatment plan fees are estimates only. Office fees change annually and may change any time due to unforeseen supply surge.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient's Name (Please Print) : _____

Signed : _____ Date : _____

Relationship to Patient : _____