

**Thomas J. DeLacey D.D.S. & Keven D. Wells D.D.S.**  
**28377 Davis Parkway Suite 609**  
**Warrenville, IL 60555**

### **Financial Policy**

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to treatment.

If your insurance does not cover your treatment, full payment is due at the time of service. We accept cash, checks or major credit cards. We offer an extended payment plan with prior approval.

#### **Regarding Insurance**

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we will bill your insurance company for you. We are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. If your account is not paid within 60 days, your balance will be transferred to self pay, and payment in full is required within 30 days. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary by your insurance carrier. You are still responsible for the above charges.

#### **Usual and Customary Rates**

We are committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

#### **Cash Plan (No Insurance)**

Payment is due at the time of service, unless other arrangements are made in advance. We accept Master Card, Visa, Discover and Citi Health Card.

#### **Collection Fees**

If it is necessary to use a collection agency to seek payment of your account, you will be responsible for all fees including the collection agency fee, attorney fees, and court costs.

A fee of \$75.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

There will be a \$30.00 charge for returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy. We hope you have a clear understanding of payment options. Please feel free to discuss options with our staff. We treat patients, not insurance companies. Any unpaid balances and associated fees for recovery are the sole responsibility of the patient.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

THOMAS J. DELACEY, D.D.S. KEVEN D. WELLS, D.D.S.

**DATE:** \_\_\_\_\_

## **PATIENT INFORMATION FORM**

NAME: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

MARTIAL STATUS \_\_\_\_\_

SEX: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### **PRIMARY INSURANCE PLAN:**

GUARANTOR: \_\_\_\_\_

SS#: \_\_\_\_\_

DOB: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

INSURANCE COMPANY NAME AND ADDRESS: \_\_\_\_\_

\_\_\_\_\_

GROUP #: \_\_\_\_\_

MEMBER ID #: \_\_\_\_\_

### **RESPONSIBLE PARTY FOR PATIENT:**

Name and Address: \_\_\_\_\_

Signature: \_\_\_\_\_

# **NOTICE OF PATIENT PRIVACY RIGHTS AND RESPONSIBILITIES**

## **MEDICAL NECESSITY**

If my insurance determines that a dental service and /or materials are not covered, I acknowledge that I have been notified and will assume full responsibility for the services and or materials.

## **DEDUCTIBLES**

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and /or provider. Yearly deductibles cannot be waived at any time by the provider of service or Dr. DeLacey, Dr. Wells.

## **PROFESSIONAL SERVICES AND MATERIALS**

I understand that I am responsible for 100% of all professional services rendered.

## **HIPAA**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected healthy information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certification.

## **AGREEMENT**

\_\_\_\_\_  
**Date of Signing**

\_\_\_\_\_  
**Guarantor/Patient Signature**

\_\_\_\_\_  
**Print Name**