Dr. Deborah Tekdogan **2805 Central Street** **Evanston, Illinois 60201**
(847-328-8500)

PAYMENT POLICY

To Our Valued Patients:

In order to keep our fees from rising and at the same time keep up with the monumental expenses of bookkeeping and billing service, we have opted to offer our patients these payment policies. This will help reduce our overhead, enabling us to provide exceptional services as well as savings to our valued patients.

1. Payment is expected at the time the service is rendered. We will accept cash, personal checks, and the following credit cards: Visa, MasterCard, and Discover. We also offer no interest financing plans through Chase Bank.

2. Non-insured patients are expected to make payment in full on the day the service is rendered, unless definite arrangements have been made with our office manager in advance.

3. Patients with dental insurance are expected to pay, on the day of service, a portion of the total fee not covered by their insurance. This "patient portion" is only an estimated dollar amount based on estimated insurance benefits.

4. As a **courtesy**, our office will file your claim with your insurance company, and work with the companies to provide reasonable information utilizing your benefits to the fullest. However, if we do not receive payment from your insurance company within 60 days, the payment becomes your responsibility). Patient is responsible to follow-up with insurance issues which cannot be resolved by our office.

5. The patient is always responsible for seeing that the ENTIRE FEE is paid in full. A 1.5% finance charge will be assessed monthly on accounts 60 days overdue.

6. Appointments missed, without a reasonable notice, will result in a $25 charge.

I have read the above policies and agree to abide by them.

Signed:_____**Date:**_____

(The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.)

EVANSTON DENTAL SPA

Dr. Deborah Tekdogan **2805 Central Street** **Evanston, Illinois 60201**
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____ have received a copy of this office's Notice of Privacy Practices and am aware of my rights as well as the rights of the dentist's office.

_____(Print Full Name)

_____(Signature)

_____(Date)

Department of Health and Human Services requires that we inform and obtain a signature from our patients once every year.

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

1. ___ Individual refused to sign.
2. ___ Communications barriers prohibited obtaining the acknowledgement.
3. ___ an emergency situation prevented us from obtaining acknowledgement.
4. ___ Other (Please Specify)

_____
_____
_____
_____.