

Financial Policy

Dr. Ronald Murphy and staff are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. It is important that you are aware of your financial responsibilities.

Please make sure that the information we have on file is accurate and up to date. This includes address, main and alternate phone numbers, employment and information about dependents.

INSURANCE

If you have dental insurance it is important to remember that insurance is a contract between a patient and the insurance company ~ we are not a party to that contract. As a courtesy to our patients, we will prepare and submit your insurance claims for the services we provide. If you have a secondary insurance policy, we will be happy to bill that carrier after the primary insurance has made their payment. Please understand that the ultimate financial responsibility for payment in full lies with the patient, not the insurance company.

PAYMENTS

We accept cash, checks, Visa, MasterCard, Discover and Third Party Financing (such as Care Credit). Returned checks are subjects to a charge based on current bank fees. Payment is due at the time service is rendered. A statement will be sent outlining the amount owed in situations where the patient has no dental insurance, or an insurance claim has been processed and a balance remains. The balance is due in full within 14 days of the statement date. If you cannot make payment in full by the due date, please call our office at (630) 879-7642. We will assist you in making payment arrangements. An 18% interest charge will be added to the unpaid balance. If an account has to be sent to collections the patient will also incur all costs related to this action.

APPOINTMENT POLICY

We are reserving time in the schedule for you, we ask that if there are any concerns or problems with your appointment that you kindly give **48 HOURS** notice.

ACKNOWLEDGEMENT

I have read this policy in its entirety. I fully understand my rights and accept full financial responsibility under its terms. This agreement shall remain in force for the duration of treatment at Dr. Ronald Murphy's office.

Signature: _____

Date: _____