VIRDIDENTAL

Office Policy

We are pleased you have chosen to receive your dental care at Virdi Dental. It is our desire to treat everyone who enters our office the way they wish to be treated in life: Respectfully, professionally, and with honesty and integrity. To achieve this, we need your understanding of, and assistance with, our office policies and procedures.

Appointments:

Please arrive 15-20 minutes early for your appointments to complete any outstanding paperwork. Bring your current dental insurance card and a photo ID.

We value the time we have set aside for your appointment. Our office will contact you via phone, text, and/ or email 24-48 hours prior to your appointment to confirm. If you cannot keep an appointment, we require 2 business days' notice. Any appointments cancelled/rescheduled within 48 hours of the appointment time does constitutes a broken appointment. All broken appointments will be charged a $50 missed appointment fee. After 2 broken appointments, we may require a deposit to reserve any further appointments. New patient appointments that are not cancelled within 24 hours WILL NOT be rescheduled. Multiple missed appointments may result in dismissal from our practice.

If you are more than 10 minutes late for your appointment, we will do our best to accommodate you, however, it may be necessary to reschedule you.

Please allow 1.5 hours for your initial appointment; this includes a comprehensive exam and complete diagnostics.

To reschedule an appointment call us at 309-764-7631. If we are not available please leave a detailed message, and we will get back to you asap.

Initial: _____

Financials:

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE.

For my convenience, I authorize Virdi Dental to release my information to my insurance company and receive payment directly from them.

If a procedure requires multiple appointments, payment is required in full at the first appointment unless prior arrangements have been made with our office manager.

Payment Options: Cash, Credit Card (All Major cards are accepted), Check, Chery Financing or CareCredit Financing. Please note: most financing plans may not exceed 12 months of payment.

Patients with Insurance:

Please keep in mind that all insurance benefits quoted are ESTIMATES ONLY. The insurance company retains the right to change their reimbursement at any time, even if benefits have been pre-estimated. I understand that treatment plans may change during the procedure, and I am financial responsible for all work completed.

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

In case of a minor: Parents accompanying their children are financially responsible for payment. Parents NOT accompanying their children to an appointment must make PRIOR arrangements for payment. Return checks will be accompanied by a $100 fee to patient's account. Use of personal checks for payments following a returned check will be prohibited.

In the case of divorce or separation: If the decree requires other parent to pay part of all of treatment costs is the authorizing parent's responsibility to collect from the other parent. Any patient over the age of 18 years is considered an adult and must sign a new demographic form.

Initial: _____

Please see back side →

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Insured Patients:

We are not in network with most dental insurance companies. The PATIENT is responsible for the ESTIMATED non-covered portion, procedures, and/or deductibles at the time of service.
It is the patient's responsibility to make us aware of any dental benefits used at another dental office as this may affect the estimated patient portion due.
Our staff can not guarantee your eligibility and coverage. We file your insurance claims as a courtesy, please remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full.
Insurance benefits are dictated by the plan your employer (self) participates with. It is the policy holders' responsibility to understand his/her benefits.

□ I understand my insurance may only provide coverage for the minimum standard of care
□ I understand the submitting of insurance and receiving a benefit is my responsibility and that any assistance from Virdi Dental is completely voluntary
□ I understand that every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible for all charges incurred.
□ Regardless of the response from my insurance carrier, I elect to follow the dentist's recommendation for optimal dental treatment
□ I understand that if I do not pay for services rendered, I will be sent to collections and will be responsible for all related fees and court costs.
We have the right to charge interest to unpaid accounts. If any action is brought to enforce the terms of this Agreement, our office will be entitled to recover its reasonable attorneys' fees, costs and expenses from the patient, In addition to any other relief to which the prevailing party may be entitled.

Required

□ I have read the above terms and conditions of Virdi Dental
□ And agree to their terms

Patient name (printed):_____

Patient signature:_____

Date:_____