Oral Health Care
110 North Oak Park Avenue
Oak Park, Illinois 60301
Tel # 708-386-8070
Fax # 708-524-0164
http://OPOHC.com

Dr. Marcel P. Krawczyk **Dr. Sharon C. Horwitz**

*In order to keep our standard of care to a level that best serve your dental needs, we ask you to observe the following guidelines.

Payment Options:
To provide with the best possible care **we require you to pay your co-payment** if you have insurance- if no insurance is active full amount is due at the time of service.

We will fill your dental insurance claim for you and wait for the estimated payment. **It becomes the patient's responsibility to cover procedures that are not covered by their insurance plan.** You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Not all services may be covered by your insurance carrier, and every insurance plan has specific exceptions.

We hope this information adequately explains the options available to you. In the space provided below, please indicate the method of payment you plan to use to make your payments:

☐ Cash, Check, or Money Order
☐ Visa / Mastercard / Discover

For accounts owing less than $25.00 we require a Credit Card to be kept on file to be charged after Insurance has paid their portion. A mailed receipt will be sent with your statement for payments processed. Please indicate what card you would like use to process payments.

Credit Card

#_____Exp:_____CVC:_____

- Should the patient default on his/her monthly payment, the patient acknowledges that further action will be taken to collect this debt. A late a fee of $25.00 will be charged to his/her account every month account is delinquent.

Cancellation Policy:

There are many times that are patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patient give the office advance notice of their need to cancel a schedule appointment, this time in turn can then be allocated to these patients in urgent need of treatment. In this way the office can be best serve the needs of all patients.

OFFICE REQUIRES A MINIMUM OF 24 HOURS NOTICE if the appointment must be cancelled. If less than 24 hours notice has been given to cancel or reschedule an appointment or the patient does not show up, a **$25 FEE WILL BE ASSESSED FOR EACH 30 MINUTES RESERVED FOR THE PATIENT.** Please note that this fee is not covered by dental insurance and payment is patient's responsibility.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Authorizing Signature: _____ Date:_____