specialist member

JOHN W. DISTEL, D.M.D., M.S.
SPECIALIST IN ENDODONTICS
JOHN W. DISTEL, D.M.D., M.S., LTD.

900 W. ROUTE 22, SUITE 160. LAKE ZURICH, ILLINOIS 60047 PHONE (847) 842-8866 FAX (847) 842-7501

FINANCIAL AGREEMENT

PATIENTS **WITHOUT** DENTAL INSURANCE COVERAGE:

1. Payment for services is DUE IN FULL UPON COMPLETION OF TREATMENT.
2. There is a possibility that your root canal may be completed in one appointment.
3. If two appointments are necessary, one-half is due each appointment.

PATIENTS **WITH** DENTAL INSURANCE COVERAGE:

1. As a courtesy to you we will submit insurance claims to your primary carrier. We will accept the insurance payment directly from your primary carrier only, but require your estimated portion **(minimum 50% if insurance cannot be verified)** of the total fee to be paid at the time of treatment. If your primary insurance company has not made payment to us in 45 days from submission, any remaining balance is due in full from you at that time. Unpaid balances after 60 days of submission may be subject to finance charges.
2. As an alternative, if you wish to pay your total fee at the time of treatment we will submit the insurance claim at completion of treatment to your primary carrier for reimbursement directly to you.
3. PLEASE NOTE: If you have secondary insurance coverage, we will submit a claim for reimbursement paid directly to you. We will not accept payment from your secondary carrier unless a balance remains after payment is received from your primary carrier.
4. If your insurance company does not assign benefits to the provider, then payment will be due as outlined in "Patients without dental insurance".
5. Services that are less than a total of $350.00 are due in full at the time of service (consultations, evaluations, emergency treatments, etc.), any reimbursement from your insurance will be directed to you.

Please remember that although we will try to assist you in every way with processing your insurance claim, the contract exists between YOU and YOUR INSURANCE COMPANY, NOT between the DOCTOR and YOUR INSURANCE COMPANY. When you commit to treatment you assume the responsibility for payment.

Method of Payment:

1. CASH OR CHECK
2. VISA, MASTERCARD, DISCOVER or AMEX
3. CARE CREDIT or THE LENDING CLUB

INTEREST ON UNPAID BALANCES:

Will be charged 60 days from the start of treatment at 18% APR.

COLLECTION FEES:

All fees incurred by this office to collect an outstanding balance will be paid by the client whose failure to pay his account caused these fees to be incurred. Submission to treatment implies consent as outlined in this service agreement.

I have read the above financial policy and agree to the terms there-in.

_____ _____

Signature Date

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CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I HEREBY GIVE MY CONSENT TO JOHN W. DISTEL, D.M.D., M.S LTD TO USE OR DISCLOSE, FOR THE PURPOSE OF CARRYING OUT TREATMENT, PAYMENT ACTIVITIES, OR HEALTHCARE OPERATIONS, ALL INFORMATION CONTAINED IN MY PATIENT RECORD OR IN THE PATIENT RECORD OF _____.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE OFFICE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVE YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

SIGNATURE

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE: _____ DATE: _____

IF YOU ARE NOT THE PATIENT, PLEASE SPECIFY YOUR RELATIONSHIP TO THE PATIENT: _____

I UNDERSTAND THAT BY NOT GIVING OR REVOKING MY CONSENT YOU MAY DECLINE TO TREAT OR TO CONTINUE TO TREAT ME.