Jack P Horbal, DDS | Kerstin E Horbal, DDS
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Financial Policy

Thank you for choosing our office as your dental care provider. We are committed to providing you and your family the best available dental care. We realize that every person's financial situation is different. For this reason, we have designed this financial policy to provide a variety of payment options to help ensure that all your dental needs are met. We ask that all responsible parties read our financial policy, initial each section and sign the bottom for our records. A copy is available on our website.

Payment Options

____ Payments for all services are due at the time services are rendered. For your convenience, we offer several payment options:

1. Cash, check, or credit card (Visa, Master Card, Discover)
2. 6-month no interest and 24-month interest payment plans are available through Care Credit.

Insurance

We are an out of network provider for all insurance plans. However, as a courtesy to you, we will bill your insurance carrier, but you are ultimately responsible for the entire bill. As a responsible party please understand:

____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract; our relationship is with you, not the insurance company. We will facilitate claims processing by supplying factual information to the insurance company. However, we will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, or "usual and customary" charges.

____ 2. All charges are your responsibility whether your insurance company pays or not. If your insurance does not remit payment within 60 days, the balance will be due in full from you.

____ 3. If any payment is made directly to you for service billed by us, you recognize an obligation to promptly remit payment to us.

Please Note

_____Any treatment plan over $1000.00 requires a 50% deposit prior to commencement with the balance due at completion.

____ Please understand that returned checks will be assessed a fee.

____ Balances not paid in a timely manner may be subject to collection and collection fees. After such default and upon referral to a collection agency or attorney by us, you will be responsible for all costs, collection agency fees, and attorney fees.

_____We request the courtesy of 24-hour notification to cancel an appointment. A fee of $50 is charged to patients who miss or cancel with insufficient notice more than 3 times in a calendar year.

We understand that temporary financial problems may affect timely payment. If such problems do arise, we encourage you to contact us promptly so that we may assist you in keeping your account in good standing. If you have any questions or concerns, we are always available to discuss this policy with you. Feel free to contact us at: 773-275-0110.

I have read the financial policy. I understand and agree to its terms.

Signature: _____ Date: _____