John Nowak, D.D.S., L.L.C.
Practice Limited to Endodontics
6143 N. Northwest Hwy.
Chicago, IL. 60631
(773)792-2369

OFFICE FINANCIAL POLICY

Please initial & sign

- _____ Insurance claims are sent on behalf of the patient to the insurance company.

- _____ We do **not** guarantee the coverage terms of the insurance company, we are only given an ***estimate*** of benefits by the insurance company.

- _____ **Payments are Due In Full upon completion of procedure**(s)- (unless otherwise discussed with Dr. Nowak),with the following types of payment options:
  - Cash
  - Check
  - Charge (VISA, Master Card, or Discover)

- _____ Treatment in our office is a **separate charge** from the permanent restoration that you will **have** do at your general dentist office after Root Canal treatment has been completed.

- _____ There will be a $35.00 non-sufficient funds assessment fee for any checks that have been returned.

- _____ Many patients need our services and in order to accomplish this in an efficient manner, we require a minimum of 24 hours notice for any appointment changes. A ***charge of $75*** will be applied for broken and missed appointments without advanced notification.

I, (name of patient) _____, acknowledge receipt of this financial policy and I agree to perform the obligations set forth by this policy agreement for payment of services rendered.

_____ _____

signature of patient(responsible party) date