**NORTHERN TRAILS DENTAL CARE**

**Patient Financial Guidelines**

Thank you for choosing Northern Trails Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is to make the cost of optimal care as easy and manageable as possible for our patients.

**The following payment options are available…**

* Cash; Check (with valid ID); Visa; Mastercard; American Express; Discover; HSA/FSA cards.
* Convenient monthly payments are available through CareCredit (subject to credit approval)
* Prepayment/Layaway plan

**With Dental Insurance**

As a courtesy to our patients with dental benefits, we will electronically submit your dental claim with all supporting attachments at the close of business on the date of treatment.

If your insurance plan sends payment to our office and we are able to estimate payment, your portion is due at the time the services are rendered. Should your plan pay less, you will receive a bill from us, and payment will be due upon receipt. For any other insurance plans, payment is due in full when the services are rendered.

Questions should be directed to your employer or purchasing agent regarding specific plan benefits.

**NO Dental Insurance? NO Problem!**

We are proud to offer our In-Office Membership Plan which gives our patients access to affordable coverage that is simple, transparent, and easy to use. ASK us how you can join today!

**Open Chair Guidelines**

**Northern Trails Dental Care** requests a **2 Business Day** notice for changes in reserved appointments.

Our office hours are Monday through Thursday 8:00am to 4:30pm.

Without this notice, we are unable to offer this valuable appointment time to a patient who would benefit from the opening. **A fee of $100may be applied to your account**.

We take into consideration emergencies, health situations, snowstorms, etc., and these situations will be considered on an individual basis.

The Open Chair Fee will need to be paid prior to any further appointments being made.

This fee is NOT charged to your insurance company and is your responsibility.

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**Patient Name (Print)**

**X**

**Authorized Signature Date Witness Initials**