DR. JOHN J. MROZEK & Dr. Philip Peluso

7017 W. Archer Ave. Chicago, IL. 60638

773-229-1050

FINANCIAL POLICY ACKNOWLEDGEMENT

The following information is to inform you of our financial policy. If, at any time, you have any questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover, and American Express credit cards. We have also partnered with CareCredit, a third-party company, to offer the flexibility of deferred interest payment options.

As a courtesy to our patients with dental insurance benefits, we do accept assignment of insurance benefits as a form of payment to help reduce your out-of-pocket expense. We will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. It is your responsibility to notify us of any changes in your dental care coverage. Providing us with this information will expedite the processing of claims. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. You are responsible for the entire balance if the submitted claims or any part of them are denied for payment. By signing this form you are accepting financial responsibility as explained above for services received.

Assignment of Benefits

I hereby assign all dental benefits, to include major dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment directly to Dr. John J. Mrozek and associates.

Authorization to Release Information

I hereby authorize Dr. John J. Mrozek and associates to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested dental services from Dr. John J. Mrozek and associates on behalf of myself and/or my dependents, and understand by making this request that I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

Name of person signing (print): _____

Relationship to Insured: _____

Signature of Insured: _____

Date: _____