PRIME ASSOCIATES ORTHODONTICS

21128 Washington Parkway
Frankfort, IL 60423
(815) 464-6465

Patient Name:_____

INSURANCE COVERAGE AND FINANCIAL ARRANGEMENTS

Our professional services are rendered to the patient on the basis that full charges will be paid by the responsible party, not by the insurance company. Insurance programs provide limited benefits or may provide no coverage for orthodontics. Any payment made by the insurance company on your behalf will reduce your obligation. It is the beneficiary's responsibility to be aware of the benefits and limitations of their policy. Some insurance companies decline benefits if your insurance card is not presented to us prior to any treatment. We will assist in preparing necessary forms for your insurance claims. These forms should be obtained from your insurance company or union.

I understand and agree, regardless of my insurance status, I am ultimately responsible for the total balance on my account for any professional services rendered. Should my account become delinquent, I agree to pay interest at the rate of 1 1/2% per month (18% annual rate) or a minimum bookkeeping charge of $15 per month. If it becomes necessary to transfer my account balance to an outside agency for collection, I agree to pay all collection costs including attorney fees incurred and I am aware that all further collection procedures will be out of the control of Pavlik & Associates.

Signature_____Date_____

___Adult Patient ____Father ____Mother ____Guardian ____Other_____

Copy of insurance card(s):