TALL GRASS
DENTAL ASSOC.

John W. Milgram, D.D.S.

24111 West 103rd Street ◆ Naperville, Illinois 60564

Phone 630.922.0005 ◆ Fax 630.922.0003

Office Policy Disclosure & Consents

Missed Appointment Fee

I agree to pay a fee to Tall Grass Dental Assoc. for failing to keep an appointment without notification 3 office days before the scheduled appointment.

Insurance, Payments, and fees

We will file your dental insurance claims for you.
If sending a minor alone for services I will provide the office with a credit charge to cover the fees for the appointment.
I agree to pay all estimated co-payments and deductibles at the time of service.
I agree to notify the office of any changes in my insurance status prior to services being rendered.
I agree to be financially responsible for my balance if my insurance company does not make payment in 45 days from the date of service.
I agree to be financially responsible for my balance if my insurance company does not pay the balance in full.
I agree to pay a fee for the collection of my outstanding balance over 60 days. (Fee is 35% of balance.)

Privacy Policy

I authorize appointment information to be left on my telephone answering machine or cell phone voice mail.
I authorize Tall Grass Dental Assoc. and its agents to communicate with any third parties (i.e. insurance carriers or other doctors) as deemed necessary regarding my health and financial information. And I authorize any third party to communicate my health and financial information to Tall Grass Dental Assoc.
I allow Tall Grass Dental Assoc. to use any photographs taken for educational and promotional purposes, without compensation.

Changes to Treatment Plans

Treatment plans are estimates only. Dental conditions may be worse than they appear in exams and in x-rays. Fillings may be deep enough to require root canal treatment. Sealants may become fillings. Fillings may be large enough to require crowns. Filling may become sensitive after a few weeks or months and require root canals and/or crowns. Conditions may require treatment from specialists.
I agree to be financially responsible for all fees that result from a change in my treatment plan.

Print All Patients' Names

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I am the person with legal authority to consent to treatment and billing regarding these patients and I understand the previous terms and conditions and agree to be bound by them.

Choose Method of Payment by Initialing

Check, Cash or Credit Card ____ Office Financing Plan_____

Print Name: _____

Signature: _____ **Date:** _____