

Gerilyn M Alfe, DMD, PC
Chicago Smile Spa
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Written Financial Policy

Thank you for choosing us! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

You can choose from:

1. Cash, Bank Check or Traveler's checks. We offer a 5% accounting courtesy adjustment to patients who pay for their entire prescribed treatment plan with any of these options at their first visit.
2. Personal check
3. Visa, Mastercard, American Express or Discover cards.
4. Outside financing options through CareCredit, CitiBank, Springstone Financial and Capital One. Any of these options may allow you to spread out low monthly payments over as long as a 5 year period.

Please note that we require payment prior to the completion of your treatment. If you chose to discontinue care before treatment is complete, your refund would be determined upon review of your case.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. As a courtesy, we will mail the necessary forms to your insurance company to expedite their reimbursement to you. You are required to pay us in full for your treatment at the time of service.

As you know, Dr. Alfe and Rima each see only one patient at a time to provide optimal care to every one. Because of that, our appointment time is very valuable. We will charge a fee of \$200 per hour booked for appointments with Dr. Alfe that are moved or cancelled within 48 business hours of your scheduled time.

Appointments with Rima that are moved or cancelled with less than 48 business hours' notice will be charged \$100 per hour booked. We do our best to accommodate our patient's requests for specific appointment times and with such short notice, it makes it challenging for us to take care of you in a timely manner. We respect your time and ask that you reciprocate by ensuring that when you reserve your appointment with us, that you do so at a time you will be able to keep. Thank you for understanding.

We charge \$30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you need and want.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)