Peter A. LoDestro, DDS

4230A Westbrook Dr., Aurora, IL 60504

803 N. Bridge St., Yorkville, IL 60560

Financial Guidelines

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality, lifetime dental care so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. ***Payment is due at the time service is provided.*** Our office accepts cash, personal checks, MasterCard, Visa and Discover. Patients paying **IN FULL** (by cash or personal check) at the time of service will receive a 5% fee reduction. Outside financing through Care Credit is available upon request and approval.

I also understand that if appointments are repeatedly missed, we reserve the right to charge a fee based upon the length of the appointment missed.

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred up to 40%.

We will be glad to handle your insurance; however, we do require that you pay your portion at the time of your dental visit. If a balance remains after you and your insurance have paid, then you will be billed directly for the amount due.

Patients with a balance, 30 or more days past due, will incur a finance charge. If you need to make payment arrangements, please contact our office as soon as possible.

We thank you for the opportunity to serve your dental health needs and welcome any questions you have concerning your care or our financial guidelines.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. The undersigned hereby authorize Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

First Name Last Name

_____ _____

Patient Signature (Parent of Child if dependent) Date