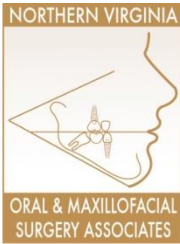

A WORD ABOUT OUR PAYMENT POLICY:

Thank you for choosing us for your oral surgery needs. We are committed to providing quality and affordable oral healthcare, and we feel that everyone benefits when there is a clear and definitive financial policy given to our patients prior to treatment. Please read, complete the requested information, and sign in the space provided. A copy will be provided to you upon request. You may also request an estimate of your charges prior to treatment.

Method of Payments:
To make your financial obligations as easy as possible we accept the following methods of payment: Cash, Check, Visa, MasterCard, American Express, and Discover.

Insurance:
We participate with many insurance plans. If you are not insured by a plan that we participate with, payment in full is expected at each visit. If you are insured by a plan that we participate with but do not have your insurance card with you, or missing a required referral, payment in full is expected for each visit until we can properly verify your coverage. Please contact your insurance with any questions you may have regarding coverage. We will assist you as we can, but knowing your insurance coverage is ultimately your responsibility.

Utilizing Your Insurance Benefits:
Patients who wish to utilize their insurance benefits must complete our patient registration form (separate page) and our payment policy form (see other side), completely, before seeing the doctor. We require the following information if you wish to use your insurance coverage for your procedure:

- **A copy of the Patient's (and/or Legal Guardian) valid driver's license.**
- **Social security number of the Patient (and/or Legal Guardian).**
- **A copy of the current valid insurance card of the Subscriber.**

Patients who do not have this information available, or prefer not to supply us with this information will be considered self-pay patients. Payment in full (cash or credit only) will be expected prior to treatment. We understand our patient's concerns for privacy of their personal information and medical records. Our practice fully complies with HIPAA regulations set by the Federal Government. Requiring the above information with insurance utilization protects our patients and our practice from possible cases of identity fraud. If you still choose to opt out of supplying us with the required information, we will supply you with the necessary information needed in order for you to file to your insurance and be reimbursed by them directly.

Claims Submission:
We make every effort to keep down the costs of care for all our patients, and one way in doing so, is to file to your primary insurance plan **only.** We will assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that your account balance is your responsibility whether or not the insurance pays on your claim. Any coverage given by your insurance is an estimate and not a guarantee of coverage or payment. Any information our staff gives regarding a patient's insurance coverage is strictly a courtesy, and not a contract of responsibility. Your insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. Patients who do have secondary insurance coverage can file a claim themselves once their primary has paid out benefits on our claim. We can supply, upon request, a copy of the primary's explanation of benefits, so that you can properly file to your secondary insurance.

Copayments and Deductibles:
For those patients who have been verified for coverage, all copayments and applicable deductibles must be paid at the time of service. This arrangement is part of your signed contract with the insurance company, and failure to pay the co-payments can be considered fraud. Please help us in upholding the law by being prepared to pay your co-payment in full at the time of treatment.

Non-Covered Services:
Please be aware that some – and perhaps all – of the procedures you receive may not be covered or not considered reasonably necessary by your insurance. Any procedure not covered, whether it be partially denied or fully, will be the responsibility of the patient. Payment in full will be expected at the time of treatment, or once the patient's claim has been processed and returned.

(Please initial ________ and continue reading)

Nonpayment:
Any balance still due after 90 days will become your responsibility whether or not insurance has processed your claim, and payment will be expected in full within the next 30 days. Partial payments will not be accepted unless otherwise arranged by our billing department. Any balance still due on an account after 120 days will be eligible for collections, and will be charged a finance charge of 1% each month until paid in full. Those accounts that are eligible for collections activity will be turned over to an attorney and/or collections agency for processing. The patient and/or legal guardian will then be responsible for ALL reasonable attorney and/or collection agency fees that will be charged in addition to the balance on the account. In the event of a returned check, there will be a $20 bank fee charged to your account, and payment in full must be made within 10 days of the returned check to avoid additional collection activity mentioned previously.

Monthly Payment Arrangements and Discounts:
As stated before, payment in full is expected at the time of treatment; however, for those patients with no insurance coverage for their procedure may be eligible for a reasonable, yet convenient payment arrangement through our billing staff. **Patients with insurance coverage are not eligible for this option**. Total charges over the amount of $800 may be divided up to four equal, monthly payments by automatic billing on your credit card. The first installment is due on the date of service. Self-pay patients, or patients not utilizing any insurance coverage, with charges over $1500 and making full payment on the date of service, will receive a 5% discount off their total charge. The doctors' sole concern is the patient's health and well-being, and they will not discuss any financial obligations. Please direct all questions and concerns regarding your financial responsibilities to our billing staff that are happy to assist you fully.

The Responsible Party (must be present for signature, at time of appointment)

Patient Name: ____

____ ____/____/____
Name of Person financially responsible (if other than patient) Relation to Patient Date of Birth

~I certify that I have read, understand, and fully accept the policies mentioned above. The above questions have been accurately answered. I understand that my insurance carrier may pay less than the actual bill for services. This signature on file is my authorization for the release of information necessary to process my claim, and that I accept full responsibility for all charges rendered on my behalf or my dependents.

____
Signature of Patient (Or Parent/Legal Responsible Party, if minor) Date