FINANCIAL POLICY

- The most common misconception concerning your dental and medical insurance policies is that they will cover the total cost of all consultations and surgical fees charged. That is most certainly not the case for almost all insurance policies. Insurance is designed to offset your cost, but usually will not eliminate it entirely. Your estimated out-of-pocket payment is due in full for each visit at our office at the time of service.

- This office will accept the following forms of payment for services rendered: Visa, MasterCard, Discover, American Express, Cashier's Check, and cash. We accept Care Credit (with the exception of the 12 month no interest), Lending Club and United Medical Credit for our 3rd party financing options. Additional fees may be added based on the plan selected with the 3rd party financing vendor. Although we do accept payment from 3rd party financing vendors, it is still the patient's responsibility to make sure the balance at this office are paid prior to surgery.

- Overpayment will be processed and refunded to the appropriate party according to generally accepted procedures. Refunds due to the patient/guarantor will not be processed and remitted until all active and past due, including bad dept accounts have been paid. This process typically takes 30 days.

- Insurance will be filed as a courtesy to the patient. However, coverage does not relieve the patient of financial responsibility, nor suspend payments until the insurance has been paid. This office will file on primary insurance only. It is the patient's responsibility to file on any secondary coverage. We will be happy to provide you with any information necessary to file.

- Upon receipt and verification of insurance benefits, we will attempt to estimate the patient's portion of the consultation and procedure fees due. However, this is only an estimate and neither the insurance company nor this office will guarantee this exact figure. The patient will be responsible for any coinsurance amounts prior to surgery.

- All patients are charged the same for services rendered. This office does not accept reasonable and customary charge calculations by outside parties unless provided in an arrangement such as a managed care contract. Any discounts/write-offs will be applied upon receipts of payments and EOB's.

- In cases of minor children with divorced parents, the parent bringing the child will be deemed the responsible party for payment. We will not be bound by a family court legal document.

- This office will send the patient or responsible party a statement showing the balance of the account after all monies have been received from the insurance company. If no insurance payment is received within sixty (60) days of service, the patient is fully responsible for payment of account. The responsible party must pay unpaid amount not covered by your insurance no later than <u>30 days</u> following insurance payment.

- If payment has not been made to an account ninety (90) days after service is rendered and contact or appropriate arrangements have not been made; the account will be referred to the necessary legal authorities. This also applies for patients with insurance. After the 3rd billing cycle the account will accrue a $50.00 billing fee/late fee.

- Should you schedule a surgery appointment and not provide a 24 hour notice for cancellations, you will be charged a **<u>$50.00 cancellation fee</u>**. We value your time so please value ours.

- For procedures other than traditional oral surgery, in order to schedule a procedure and to secure your desired date, we must obtain a $500.00 non-refundable deposit. The remaining balance of the fees will be due upon your preoperative visit or two weeks prior to your procedure. The deposit will be applied to your procedure, however if the procedure is canceled for any reason, this balance is also non-refundable except in the case of documented emergency or medical disability. If your scheduled date is changed within (3) weeks of your procedures, an additional $250.00 deposit is required.

I have read and agree to the above policies. I understand that it is my responsibility to pay any fees to this office. This signature on file is also my authorization for the release of information necessary to process any insurance claims. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Patient/Legal Guardian Signature:____**Date:**__________________________

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