

David A. Smeltzer DDS, MS
Monte E. Masonbrink DDS, MS
Oral and Facial Surgery for Adults and Children

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I understand that payment is due at the time of service unless prior arrangements have been made. I understand that although my insurance may cover a portion of my treatment, I am ultimately responsible for any balance on my account for services rendered. I also understand that my insurance is a contract between the insurance carrier and myself and **not** between the insurance carrier and the doctors. If requested, we will submit a predetermination of benefits to your Insurance Carrier. Statements for any balance remaining will be sent on a monthly basis. Any balance remaining after 90 days will incur a monthly finance charge of 1.5% (APR 18%). In the event that I default on my account, I understand that I will be responsible for any additional collection costs, attorney fees, or court costs incurred by this office. Any overpayments made will be refunded within 30 days of the final insurance payment.

I have read and fully understand the financial policies of this office.

Patient or Responsible Party

Date

RELEASE OF INFORMATION

Depending on the nature of some procedures, it may, at times, be necessary for our office to contact you regarding biopsy results or other findings and/or to schedule a follow-up appointment. If you are unable to be contacted, please list a family member or friend to whom we may disclose information. If you do not wish this information to be released to anyone other than yourself, please check the box below.

Name

Relationship

Phone

I do not wish my information to be released to anyone other than myself.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient or Responsible Party

Date