Oral & Facial Surgery for Adults & Children

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I understand that a fee will be charged for all consultations. 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 understand that any information given to me regarding finances on the day of my consultation/surgery is only an estimate. My exact responsibility will not be determined until all payments from insurance have been received and verified. 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. If payment has not been received from your insurance company within 60 days, we will request payment in full from you. We expect your payment in full, of any remaining balance, within 30 days of insurance payment. A monthly finance charge of 1.5% (APR 18%) will be applied to any account balance. 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.

40% service charge added on balances sent to collections _______ Initial Here

_________________________________ ______________

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.**

INFORMATION REGARDING NOTICE OF PRIVACY PRACTICES

I verify that I was offered a copy of the Notice of Privacy Practices for this office, as required by HIPAA.

_________________________________ ______________

Signature Date