PATIENT FINANCIAL ACKNOWLEDGEMENT

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. **PAYMENT**.

- We are pleased that you have selected our office for your oral surgery care. We have developed this form so that you fully understand your financial responsibility for your oral surgery care. Our ultimate goal is to provide the finest in oral surgery care for you or your family member. Our responsibility is to our patients and referring doctors. In order to preserve the finest doctor/patient relationship we are not contracted with any insurance carriers.
- Our staff will be happy to file a claim for your oral surgery services to your primary insurance carrier. The benefit paid by your insurance carrier for these services may be less than the amount charged. The care we provide is directly to our patient; therefore, the patient or their parent/guardian is fully responsible for all procedure fees in our office. Payment is due at the time service is rendered. Payment may be made by cash, local check (with ID), money order, MasterCard, Visa, Discover, or American Express. Financing through CareCredit may be an option for patients who desire a monthly payment plan. This option is available to pre-qualified applicants (i.e., pre-qualified directly with CareCredit prior to their appointment date) for surgical fees in excess of $500.

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- Our office is not in-network with any insurance carriers. It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- The parent, guardian, or other adult who signs in a minor child on the day of the minor's consultation appointment is financially responsible for all charges, whether or not paid by insurance, including in situations of divorce, separation, court orders, etc., the adult accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- All patients must pay in full at time of service.

3. BILLING AND COLLECTION.

- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to paid said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments.

_____	____/____/____
Patient Name	Patient DOB
_____	_____
Patient or Responsible Party Signature	Date
_____	_____
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)