

# Carolina Oral and Maxillofacial Surgery Center Financial Policy

**BASIC POLICY:** Payment for services rendered is due at the time of service. Our office accepts cash, personal checks (with valid driver's license), Visa, MasterCard, Care Credit, and Chase Health Advantage. All checks are processed electronically. There is a \$25 return check fee due and payable from you for each check payment returned to us by your bank. We do not provide in-house financing or payment plans.

**FOR PATIENTS WITH INSURANCE:** As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. **Please understand that insurance is a contract between you and your insurance company.** If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you. Please contact your insurance company to ensure your benefits are paid on your behalf.

**FOR PATIENTS WITHOUT INSURANCE:** Responsible parties without insurance agree to pay for services at the time visit. We offer a 5% discount to patients **WITHOUT** insurance coverage when paying for their procedure with **CASH** within 72 hours of their consultation appointment. This discount is not offered the day of surgery.

**MANAGED CARE PARTICIPANTS:** Some benefit plans require pre-authorization or referral forms prior to treatment. Please provide the proper insurance plan identification and forms necessary prior to your visit. All co-payments or patient out-of-pocket fees are due and payable at the time of service.

**MEDICARE PATIENTS:** The Medicare program does not cover most routine dental services, including the removal or replacement of teeth or structures directly supporting teeth. We are not required to submit claims for such services. Please ask the receptionist for more information about our Medicare policy.

**NON-COVERED CHARGES:** Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. Please ask us about outside financing available through our office.

You agree to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

**WORKERS COMPENSATION:** If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

**CANCELLATION OF APPOINTMENTS:** Our goal is to provide high quality care at a reasonable cost to our patients and in fairness to other patients and the doctor, we require 48-business hour notice when rescheduling or postponing an appointment. Any surgery scheduled for longer than 2 hours will require a 72-business hour cancellation notice. There is a loss of your deposit for missed appointments without proper notification, which will be due and payable by you. The practice reserves the right to dismiss patients with excessive cancelled appointments.

So that we may more accurately estimate your payment portion, please indicate the amount of any dental services that have been provided by your general dentist during this benefit year. \$\_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance coverage please read and sign below.**

I hereby assign all medical and/or dental benefits to which I am entitled, private insurance, and all other health plans to Dr. Richard C. Adams. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor/Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**I have read, understood and agree to the above financial policy for payment and professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.**

Guarantor/Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_