INSTITUTE OF
Facial & Oral
SURGERY

# ***Financial Policy***

We are pleased that you have selected The Institute of Facial & Oral Surgery as your Oral & Maxillofacial Surgery provider. For your knowledge, our Financial Policy is outlined below;

**Promise to Pay:** Amounts for oral surgery services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with an insurance claim; however, insurance is a contract between policy holder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments, or collection costs. We will provide you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

**Missed Appointment Fee:** We may charge to your Account a **$50.00** fee for any missed appointment or an appointment cancelled or rescheduled without advanced notice of at least 48 hours.

**Late Payment Fee:** If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of 1.50% of your unpaid balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance.

**Returned Payment Fee:** If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee of $35.00.

**Collection Cost:** If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collections, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extend not prohibited by applicable law.

**No Waiver By Us:** We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

*Please turn over to sign →*

**Credit Reports:** We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the above address.

*As used in this Financial Policy, "we," "us," "our," and "Provider" mean the service provider named above. "Services" means any services provided by us. "You," "your" and "Account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.*

**How we work with Dental Insurance:** Your treatment will be determined based on your dental needs and your health, not by your dental benefit plan. It is not in your best interest to compromise your treatment to fit an insurance program's benefits. We will discuss your treatment plan with you. You make the decision not your insurance company.

As a courtesy to you, we will accurately complete your claim form and file it your Insurance Company. Any assistance in this matter grand by our staff is given strictly as a courtesy and implies no responsibility on their part for eligibility, filing, following through or confirmation of your benefits. If your dental plan requires a pre-authorization, we will submit the appropriate documents to your insurance for review.

Our office will do its utmost to obtain your maximum benefits, but the fee for dental services is your legal responsibility and payment is expected regardless of insurance coverage. Dental benefit coverage of a specific treatment is between you, your employer, and the insurance company. ***All copayments are due at the time services are rendered; if your insurance company does not pay our office within 90 days from the date the claim was filed, you will be responsible for the amount due on your account.***

We will assist you in every way possible to file your claims, handle insurance queries, and ensure that you receive the maximum benefits of your specific insurance plan. If you have questions regarding insurance, please do not hesitate to ask our trained staff.

Please sign and date to acknowledge the above.

***Yes, I have read and agree to the above Terms and Conditions.***

---

Patient's(or Guardian) Signature  Print Name  Date