FLETCHER HILLS DENTAL IMPLANT & ORAL SURGERY CENTER FINANCLAL POLICY

PRIVATE PAY

- **Payment for services is expected at the time service is provided.**
- Cash and personal checks are accepted. MasterCard, American Express and Visapayment are: also welcome.
- If an amended payment plan is desired, please ask us about Care Credit and Citibank programs.

For services of $1,OOO or greater, a 5% courtesy discount will be extended for full cash (or check) payment in advance. I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand that I am personally responsible for payment. lf I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney' fees, plus applicable finance charges and disbursements allowances and costs provided by law shall be included in the computation of the amount due. **Finance Charges** will be applied to **all 90 days past due amounts at the APR of 1.0%**. lf the account is in default and turned over to collection, a collection fee will be added by the collection agency.

IF YOU HAVE DENTAL INSURANCE

Our office does not contract with Medi-Cal and we do not accept Workman's Comp.

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this firm.

Please remember, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Please understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney' fees, and court costs. It is important for patient' to understand that an insurance plan is a contract between the patient and the insurance company and that payment for services rendered is ultimately the patient' responsibility. Therefore, it is important for patient to fully understand their insurance policy and what they cover prior to any procedures performed. Because the process of utilizing insurance benefits can be complicated, our office will assist you in every way possible to clarify your insurance coverage and to maximize your insurance benefits. In most cases, it is impossible to determine exactly what your insurance plan will cover at the time of your consultation without a predetermination of benefits from your insurance company. That being said, a **predetermination of benefits does not always guarantee payment from your insurance company**. I understand that I may receive an estimate for treatment based on benefits that were provided by my insurance company prior to treatment. The estimate is based on benefits available on the day presented to me and is subject to change based on outstanding claims that may be pending processing by my insurance. If for whatever reason your insurance decides not to pay for treatment rendered, you are responsible to pay the balance in full. _____ Patient's initials in blank

FEES & PAYMENTS

- I certify that 1 have read and understand the above.
- The signature on file is my authorization for the release of information to process my claim. l hereby authorize payment to this doctor named of the benefits otherwise payable to me.
- I hereby acknowledge that l have been given the right to review the Notice of Privacy Practices for this office.
- I have been given the opportunity to ask any questions I may have regarding the Notice.

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, l authorize the release of any information acquired in the course of my examination and treatment to any other doctors and/or insurance carriers.

Signature of Patient (Parent or Guardian if Minor) _____ **Date** _____

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