

### ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we will do all we can to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance, and your understanding of our payment policy.

For patients who have no insurance, payment is due at the time services are rendered. We accept cash, Visa, MasterCard, American Express or Discover. For patients who have insurance, we will have reviewed this information with you at the time of your initial visit. Any estimated amount not covered by your insurance company will be due at the time services are rendered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. The amount you are quoted for your co-payment is only an ESTIMATE of your responsibility. The information we are given over the telephone by your insurance claim representative is never a guarantee of their payment.
2. Our fees are generally considered to fall within the acceptable range by most companies, and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits by all insurance contracts. Insurance companies often arbitrarily select certain services they will not cover. As a courtesy to you, a claim will be filed on the day of treatment, if no payment has been received from your insurance company within 60 day's; the balance due is your responsibility.
4. You are required to give 48 hours prior notice to our office to cancel or reschedule any appointment, failure to do so will result in a broken appointment charge.

We must emphasize that as oral surgery care providers, our **relationship is with you, not your insurance company.** While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of any balances that may remain on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

I understand and agree that, (regardless of insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

\_\_\_\_\_  
Signature (Parent or Guardian if minor)

Date: \_\_\_\_\_