Southern Maine Oral & Maxillofacial Surgery

FINANCIAL POLICY

Patient Name_____ **DOB**_____ **Date**_____

Thank you for choosing **Southern Maine Oral & Maxillofacial Surgery**. We deliver the finest care at the most reasonable costs to our patients, therefore payment is due at the time service. To avoid misunderstandings, we ask you to read and sign our financial policy prior to treatment.

You are responsible for your charges: Patients or their legal guardian are responsible for all charges incurred during treatment and must pay for services. You might have insurance or financial support from your family or others, but you remain legally responsible for your bill.

Cancellations and rescheduling appointments: We require at least **24 hours'** notice for appointment cancellations or a request to reschedule. Missed appointments and late cancellations may affect your ability to schedule future appointments with our office. Additionally, prepayment may be required before an appointment can be rescheduled.

Payment for service: For your convenience, we accept Visa, MasterCard, and Discover. We also accept cash or personal checks. In addition for those patients who require financing we offer CARECREDIT. Care Credit is a health care credit program offered to patients by an independent company. This allows payment over time, and only takes a few minutes to apply and determine eligibility.

If you do not have insurance: Payment in full is expected at time of service. Financing is available through Care Credit.

If you have insurance: As a valued service to you, we will investigate your insurance benefits, estimate your out-of-pocket costs and file claims on your behalf. You must pay for estimated out-of pocket expenses, such as estimated co-payments, deductibles, non-covered services or services requiring further review by your insurance carrier before treatment is initiated. We kindly ask that you provide us with your dental and medical insurance information prior to your appointment. Some oral and maxillofacial surgical procedures are covered by both types of insurance. If this information is not available, payment is due in full at the time of service. Although we are contracted with several medical/dental insurance companies, it is your responsibility to make sure that our providers are in your plan. Your insurance company will be able to inform you as to whether or not we participate in network or out of network.

1. To determine the amount that might be paid by your dental insurance, we can file a written pre-treatment estimate to your dental carrier upon your written request. Most carriers require 4 to 6 weeks to complete this request, so treatment will be delayed. If you receive additional dental treatment before the scheduled procedure in our office, your estimated remaining benefits could be less or non-existent. Medical insurance carriers will not provide written pre-treatment estimates. They will only inform us if you have benefits and if the services might be covered.
2. An insurance estimate is not a guarantee that your insurance company will pay exactly as estimated. Your insurance company determines the final amount paid at the time the claim is processed.
3. Verification of benefits is not a guarantee of payment by the insurance company. Final determination is made by the insurance company at the time the claim is processed.
4. Failure to provide correct insurance information on the date of service or within 15 days of acknowledgement of correct insurance, and/or any dispute that may arise regarding insurance coverage or payment is the sole obligation of the financially responsible person. Including any changes that may occur during your course of treatment.
5. Payment in full is expected 45 days after your claim has been filed by us. Insurance payments are supposed to be made by insurance companies within 30 days of filing. However, if your insurance company has not paid within 45 days, you will need to contact your insurance company to investigate claim status. If your payment is not received within 45 days of filing or if you claim is denied, you will need to pay the balance in full at that time.
6. We will cooperate with your insurance company to assist with processing your claim. Please do not submit additional claims or information to the insurance company unless specifically requested.
7. Your insurance policy is a contract between you and your insurance company. The doctors are not part of the contract. Therefore, all charges incurred are your responsibility. You are responsible for payment whether or not your insurance company pays.

Dental implant surgery: Insurance carriers provide limited coverage for dental implant and related procedures, such as bone grafting and CT scanning. Payment for these charges may need to be made in advance.

Emergency patients: Patients having emergency surgery must pay in full with credit card or cash for all charges before services are rendered.

Patients with Medicare: Dental procedures are not covered by Medicare. We are not Medicare providers, therefore payment in full is due at the time of service.

Minor patients: The parent or guardian accompanying a minor is responsible for payment of services. Regardless of insurance coverage, patients age 18 and older are responsible for payment unless a parent accompanies them to the initial appointment and signs this agreement.

Divorce and/or custody agreement situations: The parent who brings the child to the initial appointment is responsible for all charges incurred during treatment, regardless of who provides insurance coverage. Our office will not become involved in payment disputes between divorced parents.

Accident/Worker's Compensation: If your injury is a result of an accident and/or happened in your work place, please inform the receptionist immediately. We will gladly file a claim on your behalf, but in order to do so, you must provide us with all of the claim information prior to your appointment.

Lab Work: All services that require lab work will be billed by the contracted lab. You may receive a bill from Strata or NorDx. Please contact their billing department prior to calling our office. We do not have access to their billing information.

Insurance Referral: If you have an HMO medical insurance policy and are being seen for an evaluation other than extractions, you are responsible for obtaining a medical referral from your primary care physician.

Returned checks: $35 service will be charged for returned checks. Temporary or post-dated checks are not accepted.

Refunds: If payments to your account result in a credit balance after all insurance payments have been received for all dates of service a refund will be issued. Refunds are issued monthly.

Billing: If you receive a bill from us, it is because the balance is your responsibility. Insurance companies processing times vary and claims generally take 30-45 days to process. Claims involving multiple insurance plans may require additional time for each insurance company to process the claim. If you have questions about the status of your claim, please contact your insurance company first. If you have any questions about your bill, or the remaining balance please contact our office for assistance.

Collection fees: If you do not pay your balance within 30 days of receiving your first statement we will then begin the collection process. If there are any questions about a bill that you receive, please contact us immediately. If it becomes necessary for our office to use a collection service and/or legal assistance, you will be responsible for all collection/legal fees incurred including small claims court fees.

I have read the above, understand and agree to the above terms and conditions, and I agree to be responsible for total payment of my account.

_____ _____ _____ _____

Patient's signature (or financially responsible person's signature) Print Name Relationship Date

Date of Birth ____/____/____ Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Address: (if different from patient) _____

I also authorize my insurance benefits be paid directly to Southern Maine Oral & Maxillofacial Surgery.

_____ _____ _____ _____

Patient's signature (or financially responsible person's signature) Print Name Relationship Date