Hilton Head Oral & Maxillofacial Surgery

FINANCIAL POLICY

Thank you for choosing us as your oral & maxillofacial surgery provider. We are committed to your visit with us being pleasant and successful. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Patient With Insurance - I understand my insurance may only pay a portion of the cost of my treatment. My portion is due at the time of treatment. The amount collected at the time of treatment is only an *estimate*. This estimate is based on information received over the telephone or online from the insurance company. This is not a guarantee of benefit or payment. If the insurance company pays less than anticipated, or denies my claim, I will receive a statement and it will be my responsibility to pay the remaining amount due. In the event my insurance company does not make payment within 90 days, I will be notified. If payment is not received within 120 days, I understand that I am responsible for the remaining balance. If the insurance company pays more, I will be mailed a refund. As a courtesy, the office will submit a claim on my behalf, but I am ultimately responsible for the total amount due.

Patient Without Insurance - I understand payment in full is expected at the time of treatment.

Methods of Payment - Cash, Check, Visa, Mastercard, American Express, Discover, and Care Credit.

Returned Checks - I understand a $35.00 fee will be added to my account balance for any returned checks.

Service Fee - I agree that a max of 30% collection fee will be added to my balance owed should my account be forwarded to a collection agency for recovery. I understand that any attorney and court fees incurred in the collection process will also be guaranteed by me.

Minor Patient - A patient age seventeen or younger is considered a minor. An adult or guardian must accompany the patient for treatment. The adult accompanying the patient *and* the parent(s) are financially responsible for the account. In the event the parents are divorced, the settlement must be resolved between the parents. For unaccompanied minors, non-emergency treatment will be denied.

Authorization to Release Information - I hereby authorize Hilton Head Oral & Maxillofacial Surgery to release information acquired in the course of examination and/or treatment for insurance claims processing and/or legal purposes.

You are entitled to a copy of this contract for your records

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Signature of Patient or Responsible Party Date

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Witness (Staff Member) Date