MIDWEST ORAL SURGERY FINANCIAL POLICY

PAYMENT FOR SERVICE

The payment for medical and dental services is the patient's responsibility. Our policy requires payment at the time the service is performed. Payments can be made by cash, check, major credit cards, health savings accounts, and various forms of financing. Please note: Mastercard, Visa, Discover, and American Express will be charged a 2% Convenience Fee will be added to your credit card payments. This fee ***does not apply to cash, checks, HSA, and debit cards***. If other arrangements are needed, please ask so that we may assist you. **We do not accept temporary or post-dated checks. A <u>$20.00 fee</u> will be assessed on returned checks.**

INSURANCE

Verification of benefits is not a guarantee of payment by your insurance company; final determination is made by your insurance company at the time the claim is received.

- **<u>CONTRACTED INSURANCE PLANS (HMO, PPO, DMO, etc.)</u>**
  - If our office has a contract with your insurance company, we will file all claims with them. You are responsible for payment of an ***<u>estimated deposit</u>*** on your co-insurance or co-pay at the time of service. It is the patient's responsibility to obtain required authorizations from the insurance company or primary care physician for each visit. Failure to have a current authorization could result in (1) rescheduling your appointment or (2) payment in full for all services relating to this appointment.
  - If your treatment results in an out-of-pocket expense more than $4,000 we will collect 50% at the time of scheduling. The remaining balance will be collected the day of your procedure.
  - *Per Missouri Statute Section 376.1226 for non-covered services no contract between a health benefit plan and provider shall require the dentist to provide services at a fee established by the health benefit plan*.
  - We are happy to file insurance claims for you (excluding Medicare or Medicaid), after verification of eligibility and benefits. Filing your claim does not take the place of your responsibility to pay for services rendered.

- **<u>OFFICE VISIT/CONSULTATION</u>**
  - An office visit/consultation with the Oral and Maxillofacial Surgeon is required for all patients that are referred to Midwest Oral Surgery. There is a cost to the consultation. Midwest Oral Surgery <u>does not</u> offer free consultations. Many dental insurance companies have rules that only allow a certain amount of dental office visits per year. This is more commonly known as a "Frequency Limitation." Dental insurances do not differentiate a visit to your general dentist from a visit to a dental specialist, such as an Oral Surgeon. If the insurance company has not processed the latest dental visit claim from your referring provider then we have no way of knowing that the frequency limitation may have been met. Therefore, in this case, there would be a balance due from the patient for the Office Visit.
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After we receive final payment or denial from your insurance company, you will be billed for the remaining balance on your account. If, after 60 days, your account remains unpaid by your insurance, you will be responsible for the balance. In the event of an overpayment on your account, a refund will be sent to you within 60 business days. It is important to recognize that your insurance policy is an agreement between <u>YOU</u> and your insurance company. Your benefit assignment does not take the place of your responsibility to pay for services rendered. If your balance is turned over to a third party for collections a 25% service charge will be applied.

In cases of divorced parents, the parent bringing the child to the initial visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I have read the above and understand that I am responsible for all office charges. I also understand that once payment has been received from my insurance company, any balance remaining on my account will be due within 30 days. I authorize the release of any medical or dental information necessary to process insurance claims and request payment of benefits to the provider of services. I understand that I will be responsible for all collection costs, attorney's fees, and/or court costs.

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Name of Responsible Party (Please Print)

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Signature of Responsible Party **Date**

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Patient Name if different than the Responsible Party