OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

PLEASE BE ADVISED THAT WE CANNOT GUARANTEE YOUR INSURANCE COVERAGE FOR ANY SERVICES RENDERED IN OUR OFFICE. YOU WILL NEED TO CALL YOUR INSURANCE COMPANY DIRECTLY TO CONFIRM YOUR COVERAGE IS SHOWING EFFECTIVE AND TO DETERMINE IF THE PROCEDURE IS AN ELIGIBLE SERVICE!!

REGARDING INSURANCE

If you do not have insurance, we expect payment in full for all treatment rendered at the time of service unless other arrangements have been made. We accept cash, checks, money orders, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT. Please be advised that all payments made with personal checks will be deposited electronically to our account. Any checks returned for non-sufficient funds or stop payments will be charged a $30.00 service fee.

If you have insurance, we will help you receive maximum benefits. We *participate* with many insurance companies. However, not all of the contracts are the same, and certain services may not be covered depending on your employee benefits. We will send a bill to your insurance company for any ***covered*** services done in our office.

- You are responsible for paying the bill for any ***non-covered*** services in full at the time of service.
- You are responsible for any deductibles or co-payments at the time of service.
- You are responsible for any co-insurance at the time of service.
- **You are responsible for prompt payment of your account**. If payment is not received from your insurance company within ninety (90) days, the balance on the account becomes your responsibility.

HIPAA

I hereby acknowledge that I have received or been offered a copy of this office's Notice of Privacy Practices as is required by law.

STATEMENT OF FINANCIAL RESPONSIBILITY

I have read the above Financial Policy and understand that I am financially responsible to pay any charges that are not paid by my insurance(s) or any other party. I understand and agree that a monthly finance charge of 1.5% may be added to my account if my balance is not paid in full within thirty (30) days. If Miller Oral Surgery needs to use a collection agency or attorney to collect the unpaid amount, the patient will be charged for all fees and costs to Miller Oral Surgery by way of a 30% collection fee added to my account.

Patient Name:____ Date:______________

Responsible Party (Please Print):____

Responsible Party Signature:____