

OFFICE FINANCIAL POLICY

1. It is the intent of this office to ASSIST you with your insurance benefit information. **The only medical plan we participate with is Horizon BCBS. The only dental plans we participate with are Delta Dental, Horizon traditional plan and Cigna Dental PPO (radius network).**
2. We are NOT responsible for ANY information provided to us as a courtesy to you by your insurance company.
3. It is difficult to obtain reliable financial information from insurance companies regarding oral surgery procedures. **Contract allowances have many conditions for eligibility established by the insurance carrier not based on need** for the service. These conditions for eligibility continually change and we are not apprised of the changes.

Treatment Fee and Payment:

- Payment is expected at time of treatment.
- Financial arrangements can be made in **advance** of your appointment.
 - Estimated payments are due at the time of your appointment.
- Pretreatment estimates can be submitted to your insurance company so that they can provide you with financial information regarding the amount they will or will not pay towards the above treatment. Any quotes are ESTIMATES only. We will do our best to help you with insurance information from your insurance company.

I understand that ESTIMATES of insurance benefits for services performed both verbal and written are only ESTIMATES. I understand this office attempts to obtain information about YOUR BENEFITS as a courtesy to you. I understand that **any information this office provides you regarding benefit coverage is not a guarantee in any respect that the insurance company will pay this amount. I will not hold this office responsible for benefit information obtained on MY behalf. The information may not be accurate. Ultimately, this information is your responsibility, we are only assisting you.**

I understand that my dental or medical insurance carrier may pay less than the actual fee and/or estimate for services provided in writing and verbally. ALL estimates are nonbinding. I agree to be responsible for payment of all services rendered on my behalf or my dependents. A service charge of 1.5% per month will be charged on all unpaid balances over 60 days. There will be a service charge of \$25.00 for all returned checks. If my account is turned over to a collection agency I will be responsible to pay an administrative fee of \$50.00. If you have paid a deposit for your procedure and cancel less than 2 business days before the appointment, you forfeit your deposit.

- I authorize Optimum Oral Surgery Group to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and /or other health practitioners.
- I assign and request my insurance company to pay directly to Optimum Oral Surgery Group, LLC. benefits otherwise payable to me.

All balances are due in full 90 days after treatment **regardless of insurances intent to pay.**

I have read and understand the above entirely.

Signature Guarantor: _____ Date: _____
Print Name Clearly: _____