



WOODBIDGE ORAL AND MAXILLOFACIAL SURGERY

FINANCIAL POLICY

The Woodbridge Oral & Maxillofacial Surgery Center mission is to provide the highest quality care in a comfortable and caring environment to each and every patient. We pride ourselves on our patient-centered practice, where we perform the highest level of care and service in a clean and well-organized environment. All recommended treatments are in the best interest of our patients. We will not allow your dental insurance to dictate your treatment plan; therefore we will inform you before we perform any recommended treatment.

FEE & PAYMENT

We make every effort to keep down cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office depending on the special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. This estimate is not a guarantee of actual procedures performed or fee contracted by your insurance company, but a good-faith attempt to calculate the subscriber's liability for the recommended procedures. If you have any dental or medical insurance, we will be glad to complete and submit the proper forms to the extent of the information you provide to us. We will only submit claims on your behalf to primary insurance provider.

Your health insurance is not a substitute for payment, it is only consider as a method of reimbursing the patient for the incurred fees. It is your responsibility to pay any balance not paid by your insurance company. Accounts not paid in full within 90 days will be turned over to collection agency. You will be responsible for all collection cost, attorney's fees, interest and court costs.

EMERGENCY PATIENTS

Please note that our policy requires verification of insurance. In the event that we are not able to verify your insurance information, payment will be due at the time of service. We will assist you in submitting a claim to your insurance company, so that the insurance company will reimburse you directly for your visit.

APPOINTMENTS

Your appointment is a time especially reserved for you and for your dental care needs. We strive to give each patient a courtesy call one two days in advance of your scheduled dental visit. However, you are expected to keep your appointment time with or without the courtesy call. Therefore we ask your consideration that you kindly give 48-hour notice if you are unable to keep your appointment is not given. Please note that if 48-hour notice is not given, (by 11 a.m. Friday for a Monday appointment), **\$100.00 fee appointment is what you will be charged.**

PREFERRED METHOD OF PAYMENT

For your convenience, we accept Cash, ATM/Check cards and all Major Credit Cards – American Express, MasterCard, Visa, Discover, and Checks (with proper I.D.). We also use an automated telecheck service, which electronically withdraws the payment from your account or insures payment. There will be a fifty dollar (\$50) returned check fee applied to your account in the bank denies your check for any reason. As an added courtesy, we also offer a revolving line of credit through a third party (upon credit approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time. Please feel free to ask our business coordinator if you are interested in this type of payment.

The parent or guardian that brings a minor in for treatment is the financially responsible party. Financial arrangements between individual parental parties do not absolve the parent bringing the minor from their financial obligation to our practice.

By signing below, I acknowledge that I have read, understand, and agree to the provisions of the above policy.

PATIENT'S NAME: _____

PARENT/GUARDIAN NAME: _____

(IF PATIENT IS A MINOR)

PATIENT SIGNATURE: _____ **DATE:** _____