IMPLANT & ORAL SURGERY CENTER AT MAPLE LAWN

FINANCIAL POLICY

Patient Name: _____
Date:_____

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license) and all major credit/debit cards. There is a $35 returned check fee due and payable from you for each check payment returned to us by your bank. Outstanding balances will be subject to finance charges and late fees.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper information and paperwork is available to us. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

SURGERY FEES: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Your insurance carrier may require prior authorization.

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial

WORKERS COMPENSATION: If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

PERSONAL INJURY CASES: This office does not accept liens nor bill for auto-accident or other liability or lawsuit-related cases. The patient is responsible for services provided at the time of service.

FOLLOW-UP VISITS: Periodic post-operative office visits may or may not be covered under your insurance plan; however, these may be required by the attending doctor to monitor your health.

CANCELLATION OF APPOINTMENTS: Our goal is to provide access to high quality care and in fairness to other patients and the doctor, we require at least 24 hours' notice when canceling an appointment. There is a $75 fee for missed appointments without 24-hour notification, which will be due and payable from you. The practice reserves the right to dismiss patients with excessive cancelled appointments.

Please check one: I have paid my insurance deductible for the current year ☐ Yes ☐ No ☐ Don't Know

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Jay Haddad. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.

Guarantor / Patient's Signature _____**Date** _____