

Granbury Oral and Facial Surgery

Office Financial Policy

BASIC POLICY: Payment for services rendered is due in full at the time of service. A 10% down payment is required at least 72 hours prior to any scheduled procedure in order to secure your appointment time. There is a \$30 returned check fee due and payable from you for each check payment returned to us by your bank. A collection charge of 35% of the remaining balance, not to exceed \$40, will be added to any additional delinquent accounts.

FOR PATIENTS WITH IN NETWORK INSURANCE: As a service to our patients, we will accept “assignment of benefits” and will bill your insurance carrier, provided proper paperwork is provided in advance. We do not bill secondary insurance but will provide information to aid you in the process. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of the service, **but the ultimate responsibility for the unpaid balance rests on you.**

FOR PATIENTS WITH OUT OF NETWORK INSURANCE: As a service to our patients, we will accept “assignment of benefits” and will bill your insurance carrier, provided proper paperwork is provided in advance. We do not bill secondary insurance but will provide information to aid you in the process. Every effort will be made to closely **estimate** your co-payments and deductibles, which are due at the time of the service, **but the ultimate responsibility for the 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.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality care at a reasonable cost to our patients. In fairness to other patients, and the doctor, we require at least 72 hours notice when cancelling a consultation appointment. **There is a \$50 fee for missed appointments without a 72 hour notification.** We will require information for a valid credit/debit card in order to book a consultation appointment. Failure to cancel a consultation appointment with at least 72 hours notice will result in a \$50 fee.

I understand that my signature requests payment to be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA – 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion or such charges.

Patient’s Name (please print) _____

Responsible Party’s signature _____

I agree to be responsible for all charges for rendered oral surgical services and materials not paid for by my dental or medical insurance carrier, unless the provider or practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Patient and/or responsible party’s signature _____ **Today’s date** _____

I hereby authorize payment of dental or medical benefits otherwise payable to me directly to the practice Granbury Oral and Facial Surgery, Dr. Eduardo Humes.

Patient and /or responsible party’s signature _____ **Today’s date** _____