

Dr. Charles Stone Jr. D.D.S. & Dr Barry Acker D.D.S.
Oral & Maxillofacial Surgery
Office Policy For Payment

There can often be misunderstandings when it comes to payment in a medical office; therefore we have designed an office policy to help explain to our patients the financial part of their surgery.

_____ **1. Payment is due the day of surgery.** Cash/Check/Visa/MasterCard/American Express/CareCredit

_____ **2. Insurance:** If insurance is involved, a down payment is expected the day of surgery. The down payment for the surgery is an **estimate** of what the insurance will not cover. **We do not guarantee that your insurance company will pay what we have estimated, therefore, you may have a balance after your insurance company pays.** Every insurance company has their own fee schedule; therefore we can not determine how much you will be responsible for unless a predetermination is sent to your insurance company. A predetermination takes approximately 4 to 6 weeks. **A down payment of 30-50% is required if a predetermination is not filed.**

- **Physician referrals for insurance purposes:** It is your responsibility to furnish a referral from your primary care physician before your consultation and surgery.
- **Secondary insurance.** We do not accept secondary insurance as your down payment. We will give you a copy of the claim so you can submit it to your secondary.
- I, _____, understand that I will be responsible for what my insurance does not pay.
- Most insurance companies will pay the claims within 60 days. After that time we will request that you settle the account and let the insurance company reimburse you. We suggest that you call your insurance company 30 days after your surgery to confirm it is being processed. We can re-file the claim at your request. If your insurance has a fee schedule or yearly maximum, you could have a balance after the insurance payment is received. Call your insurance company if this is a concern.

I have reviewed this following treatment plan. I authorize release of any information relating to this claim.

X _____
Signed (Patient or Parent if minor) Date

I hereby authorize payment directly to the below named doctor of the insurance benefits otherwise payable to me.

X _____
Signed (Patient or Parent if minor) Date

_____ **3.** There is a service charge of **\$25.00** on all returned checks. A photo ID is required on all checks.

_____ **4.** All accounts over **120 days** will be turned over for collections.

_____ **5.** When a minor patient is brought to our office, the parent that brings them is responsible for the child's fee.

I understand the financial policy and accept the terms as written. A photocopy of this document is considered valid as the original.

X _____
Signed (Patient or Parent if minor) Date