IMPACT

oral surgery

OFFICE FINANCIAL POLICY

Please read and sign before your consult.

Payment is due in full at the time services are rendered. We will give you an estimated percentage your insurance will not cover at the time of service. If for any reason your insurance company should pay less than the estimated amount, the remaining balance will be your responsibility.

If you are not insured, payment is due the day services are rendered. We will require the full amount unpaid by insurance on the day services are rendered and we will bill your insurance company for the difference. Our policy is to allow a 30-day grace period from the date of services rendered for your insurance company to pay the difference. Once your account reaches 30 days past due the balance becomes your responsibility and is due immediately. If you fail to pay your account in full or if satisfactory payment arrangements are not timely made and timely payments are not made pursuant to the payment arrangement within 90 days following your office visit, we may refer your account to our collection agency. Your account could be reported to the credit bureau.

Services provided by others (laboratories, etc.) outside of this practice are not part of the treatment fee, and are your responsibility.

PAYMENT TYPES | We accept cash, check, Visa, MasterCard, Discover and American Express as payment in our office. We charge $30.00 on all returned checks.

Care Credit: *Care Credit is a third-party dental/medical lender. We offer this as a payment plan option and can assist you with this application if you so choose.*

By signing below, I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment and to the use of same by this practice for any reasonable purpose.

By signing below, I authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

You agree, in order for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain n effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that Impact Oral Surgery or affiliated collection agency may contact me as described above.

Signature of patient or responsible party *Date*

JOHN BATSON, DDS

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