Oral Surgery Group, Inc.

Oral Surgery Group's Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to any treatment.

Payment for Service

Payment for all services is due at the time services are rendered unless alternate arrangements for payment have been made with our staff in advance. All co-pays must be made at the time of service according to contract.

Regarding Insurance

If you have dental/medical insurance, we are happy to help you receive the maximum allowable benefit. In that regard, we will provide you with all of the information necessary to file a claim, or if you prefer, we will file a claim for you. In either case, it is important to understand that, as a health care provider, our relationship is with you and not with your insurance company. As a result, it is the patient who is ultimately responsible for any and all charges not covered (for whatever reason) by insurance.

I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made on my behalf to the Oral Surgery Group, Inc. for any services furnished me by that facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, the Medicaid program administrator and/or other insurance companies any information needed to determine these benefits or the benefits payable for related services.

Usual and Customary Rates

Our practice is committed to the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Pre-certification

Many insurance companies (especially HMO/Managed Health Care Plans) may require that you obtain authorization from your Primary Care Physician and/or from your carrier prior to services being rendered. Our staff will be happy to assist in understanding how to obtain the necessary authorizations. However, it is the responsibility of the patient to make sure it is obtained (if required) and the patient is financially responsible if the precertification is not so obtained. Oral Surgery Group, Inc. will not refuse treatment due to lack of an authorization.

Minor Patients

The adult accompanying a minor and the parents/guardians of the minor are responsible for payment of any and all charges not covered by insurance.

Missed Appointments

Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION AND RELEASE

I (We) have read and understand the Financial Policy of the Oral Surgery Group, Inc. set out above. Specifically, I (We) understand that I (We) am/are responsible for any and all charges not paid by insurance within 60 days. Should it become necessary for the Oral Surgery Group, Inc. to turn my account over to a collection agency or attorney, I (We) understand that I (We) will also be responsible for any costs of collection, including reasonable attorney fees. If for any reason my account should become delinquent (late), I agree to be tried in a court in Lake County, Indiana.

I (We) understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it is revoked in writing.

I (We) have received a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Signature Date Financial Responsible Party Signature Date

Account #: _____SS#: _____ Phone #: _____ DOB: _____

I give permission for Oral Surgery Group to leave a message on my voice mail regarding appointments: _____Yes _____ No

I give Oral Surgery Group authorization to communicate with the following person(s) regarding any services provided to me including financial and health information:

_____ _____

Contact Person (Relation to Patient) Patient Signature Date

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: Individual refused to sign. Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement. Other (Please specify below)