-R & R DENTAL SPECIALISTS, PC

FINANCIAL POLICY

Thank you for choosing R & R Dental Specialists, PC for your Oral and Maxillofacial Surgery care. Our office is committed to the highest level of patient care. The payment for services rendered is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to starting any treatment. Please read carefully and contact us with any questions that may arise.

Appointment Charges

All appointments including Consultations, Exams, Treatment and Surgeries carry a fee that is charged to the patient. If your insurance company does not pay for the appointment or charges, then it is your responsibility to pay any unpaid or denied balances. **We will take our own Panoramic Xray on every patient as it is necessary to diagnose treatment needed. You can request a quote of charges for your appointment if needed.**

Payments Accepted

We accept the following forms of payment: cash, personal check (**with Driver's License & Check Verification**), Visa, MasterCard American Express and Discover. (**NO BUSINESS CHECKS**.) We also offer extended payment plan options through Care Credit (upon credit approval).

All patient portion of fees, insurance co-pays, and deductibles are due at the time that services are rendered

The parent/legal guardian of any minor is responsible for their account. Any checks returned for insufficient funds are subject to a $30.00 additional fee. This charge covers processing fees incurred by our office.

Regarding Insurance

I understand that my personal information will be used in order to obtain my insurance verification of benefits. I also understand that my personal information will be sent on a claim to my insurance company to obtain payments for my visits. As a courtesy, we will file your claims to your insurance company. Your fees will be estimated on the basis of your primary insurance policy. Once your primary policy has paid, we would be happy to help file a claim to your secondary policy in which you would receive reimbursement of any amounts paid. It is ultimately your responsibility to keep track of any insurance balances or maximums remaining or used from all doctors you have seen. If your insurance maximum is depleted at the time of the receipt of our claim then you are responsible for your account balance. **YOU MUST PRESENT YOUR PICTURE ID IN ORDER FOR US TO FILE YOUR INSURANCE.**

We provide services based on clinical relevance and standard-of-care, not based on insurance acceptance. Your insurance policy is a contract between you and the insurance company. We are not a party to that contract, and don't have the power to make your insurance company pay. Some services may be deemed "not necessary" or "not covered" by your insurance company. For this purpose, we will gladly submit a pre-treatment estimate. However, any pre-treatment estimate is an ESTIMATE only. Actual charges may be higher or lower, depending on the nature of your procedure. Additionally, please understand pre-treatment estimates typically take 4-6 weeks to complete.

Please bring to each visit your current insurance card and/or information. We will do our best to estimate accurate insurance coverage and patient portions due. However, it must be understood that each PATIENT is ultimately responsible for the cost of services rendered. Your insurance company is required by law to pay on claims within 30 days. Whatever part of your claim that insurance does not pay after 30 days becomes your full responsibility. You are responsible for any fees incurred in obtaining any unpaid balances, which may include billing, collections or attorney fees. Interest at the rate of 1.5% per month or 18% annum may be charged on balances unpaid after 45 days.

We appreciate the opportunity to serve your Oral and Maxillofacial Surgery needs and welcome any questions you may have regarding our financial policy. By signing below you acknowledge that you have read, understand, had any questions answered and agree to abide by this policy.

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SIGNATURE	**PRINT**	**DATE**