Financial Policy

Foothill Oral Surgery Center

_____ Payment is due when services are rendered. If you have dental insurance, it is our policy to collect all co-payments and deductibles at the time of service. There is a $50.00 returned check fee

_____ A credit card is required to be on file to schedule appointments. It will be billed a $50 cancellation fee if a scheduled appointment is missed without at least 2 business days advance notice. Example: An appointment on a Monday, requires cancellation and rescheduling **by end of day Wednesday the week before**, in order to not be assessed the cancellation fee.

_____ A credit card is also used to guarantee all amounts due on your account. If you do not wish to use your credit card on file to guarantee your account, we can not extend credit to you in the form of an outstanding insurance receivable. If you do not leave a credit card to guarantee your account, you will need to pay in full for all services at the time they are rendered.

_____ If you do leave a credit card to guarantee your account, once the insurance has paid, or when 60 days has passed, whichever comes first, any remaining balance due on your account will be paid with the credit card on file. Once your account is paid in full, a statement and any applicable receipts will be sent to you. If insurance pays us after your credit card is used to pay your balance, you will be reimbursed.

_____ In order to keep from having to pay the entire receivable balance after 60 days, we suggest you stay in contact with your insurance company. Encourage them to pay in a timely manner. Please understand that your insurance coverage is a contract between you and your insurance company, not this office. We cannot take responsibility for large out of pocket costs, special claim forms, or delays and denials. You are ultimately responsible for payment of your account in full and your credit card on file will be used to fulfill that responsibility.

_____ If you have questions regarding your insurance coverage, please discuss it with your insurance company prior to your visit. We are happy to assist you in determining what benefits are available to you, but this is not a guarantee of payment by the insurance company or a pre-authorization of benefits, and does not supplant the need for you to contact your insurance company directly to determine your benefits. Filing an insurance claim is a service provided without charge but in no way relieves you of responsibility for your bill.

By signing this policy, you acknowledge that you have read and understand this agreement and are accepting primary responsibility for all services rendered. You also give us authorization to charge the credit card listed above for any balances due on your account after your insurance has paid, or when 60 days has lapsed from the time service was rendered, whichever comes first. In the event, the above credit card is declined, interest will accrue on the account balance at the rate of 1% per month commencing the day the transaction was denied. If you do not leave a credit card to guarantee your account, you will need to pay in full for all services rendered at the time they are rendered and no credit will be extended to you in the form of an insurance receivable.

Responsible Party's Signature _____ **Date**_____

INSURANCE AUTHORIZATION – SIGNATURE ON FILE.

I hereby authorize Foothill Oral Surgery Center to affix my name to all insurance submissions, documents and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependents and me. I also authorize payment of healthcare benefits otherwise payable to me, directly to Foothill Oral Surgery Center. I agree I am responsible for all charges and services not paid by my insurance company. A copy of this authorization may act as an original.

Patient or Insured's Signature _____ **Date**_____

CREDIT CARD ON FILE FOR PURPOSES OUTLINED ABOVE:

Responsible party (Name on Credit Card) _____

M/C Visa Disc AMX Credit Card # _____

Exp. Date _____ CID _____

CREDIT CARD HOLDER SIGNATURE _____ Date_____