F.O.S.C. Financial Policy for Patients with Insurance

It is our policy to collect all co-payment and deductibles at the time of service. You will be asked below to provide a credit card to guarantee all amounts due. We will send you a *statement* once the insurance has paid, or when 60 days has passed, whichever comes first. Any amount due upon receipt of the *statement* will be paid with the credit card on file, unless you send payment to us within 30 days of the statement date. If your credit card on file is used to pay your balance, a courtesy phone call will be made to inform you of the charge. A receipt of the transaction will be sent to you as well. If insurance pays us after you have paid your balance, you will be reimbursed. **Initials _____**

In order to keep from having to pay the balance in full 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. **Initials _____**

If you have questions regarding your insurance coverage, please discuss it with your insurance company prior to your visit. They can help you determine the extent of your coverage. Although we can assist you in determining your benefits, this 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. **Initials _____**

PPO: We are an in-network provider for **Guardian, Delta Dental, and Blue Cross**. Most PPO plans do allow for out-of-network benefits, you should contact your insurance company to determine if the cost would be higher.

HMO: We are not a part of any HMO plans; payment in full is due at the time of service.

Medicare: We do not accept assignment.

Returned Checks: There is a $50.00 returned check fee.

CREDIT CARD ON FILE

(Circle): Visa MasterCard American Express Discover Care Credit

Acct. No. _____Sec. Code_____ Exp. Date_____

_____ _____

Cardholder name (Please Print) **Signature**

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 60 days has lapsed from the time service was rendered, whichever comes first. In the event, the above credit card is denied, 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 the account, then interest will begin accruing at 1% per month after 60 days on any balance due.

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 dependants 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_____