# MID ATLANTIC IMPLANT AND ORAL SURGERY CENTER

******Financial Agreement******

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial agreement. If you have any questions about the agreement, please discuss them with the office manager.

Insurance is filed **only once** as a courtesy to you. This is NOT a guarantee of benefits and **it is your responsibility to verify coverage.** If no payment is received from your carrier within 45 days, a tracer will be sent to you insurance company and you will be asked to pay your **balance in full.** If your carrier pays at a later date you will be reimbursed immediately.

**YOUR INSURANCE IS YOUR RESPONSIBILITY**

Your carrier has a contract with **YOU**, and although we file claims for your convenience, You are ultimately responsible for **ALL** charges, covered or not covered, including **general anesthesia and 3rd molar extractions,** I, _____ have read and fully understand the preceding paragraph.

- We have made prior arrangements with several insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay the estimated co-payment or percentages at the time of service. If you have insurance coverage with a plan we do not have a prior agreement we will prepare and send the claim for you. **You will be required to pay 50% of our fees.** If the insurance company pays more than 50% of our fees you will be reimbursed. If they pay less than 50% of our fees you will be billed for the balance. If you would rather pay for the fees in full and have the insurance company pay you directly please speak with the office manager.

- If your insurance benefit is a discount plan the discounted fee **must** be paid in FULL on the date of service or the discount is not given. If a check is returned to us on the discounted fee plan the full fees will be required, plus the returned check fee.

- We will look to the adult, parent of guardian with **custody**, accompanying the patient, for payment of all services rendered. The responsible party for any services rendered must be present to sign this financial agreement prior to services being rendered.

- If you do not have insurance benefits, all fees are due at the time services are rendered.

- Account balances over 30 days will accrue interest at a rate of 1 ½ % per month of the outstanding balance (18% APR). Failure to comply with the terms of this financial agreement will result in collection procedures. All collection costs including court cost, accrued interest, collection agency fees **(33.3%)**, and the attorney fees **(33.3%)** will be added to the outstanding balance.

- The undersigned agrees to be financially responsible for all dental, medical and/or surgical services provided by Mid Atlantic Implant and Oral Surgery Center, P.C.

- **<u>If it becomes necessary to change or cancel your appointment we require 24 hours notice or your account will be charged $100.00 for general anesthesia/sedation appointments, or $50.00 for other types of surgical appointments. You will be rescheduled for treatment once your broken appointment fee has been paid in full. If you break two appointments, you will be dismissed from our practice.</u>**

- By signature, I acknowledge that I have read and fully understand the terms of this agreement.

_____

Signature of Responsible Party  Print Name  Date