St. Louis County Oral & Maxillofacial Surgery

Financial Policy

Welcome to St. Louis County Oral & Maxillofacial Surgery. We ask that you read and sign our financial policy prior to any treatment. To avoid misunderstandings, please ask us if you have questions about our policies.

Payment for service: Our policy requires payment for services at the time service is provided. If special arrangements are needed, please discuss those arrangements with your doctor prior to your surgery.

Method of payment: Our office accepts cash, personal checks, MasterCard, VISA, Discover and CareCredit®.

Insurance: As a courtesy to you, we will verify your insurance benefits, estimate your co-insurance (what you owe) at the time of your appointment and file your insurance claims. To do this we must have complete and accurate information from you.

- **Verification of benefits** is not a guarantee of payment by your insurance company; final determination is made by your insurance company at the time the claim is received.
- An **insurance estimate** is not a guarantee that your insurance will pay exactly as estimated. Your insurance company determines the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- You are responsible for payment of **estimated co-insurance, deductible, co-pay or non-covered services** at the time of service. We will file all claims with your insurance company.
- To determine exactly what amount will be covered by insurance, we will gladly request **pre-determination** by your carrier. This request may take up to four weeks to be processed by the insurance company.
- **All charges you incur are your responsibility**. Your insurance policy is a contract between you and your insurance company. You are responsible for payment whether or not your insurance pays.
- It is your responsibility to obtain **required authorizations or referrals** from the insurance company or primary care physician for each visit. Failure to have a current authorization could result in our rescheduling your appointment or requiring payment in full for all services relating to the appointment.
- We ask that you sign this form and any necessary documents that may be required by your insurance company.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not paid within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim has been denied, you will be responsible for the full amount at that time.
- We will cooperate fully with your insurance company to assist in the claim being paid.

Non-insured: If you do not have insurance or our office is not a participating provider with your insurance plan, full payment is due at the time of service.

Patients with Medicare: Dental procedures are not billable expenses to Medicare. However, if you will be having a medical procedure, we will ask you to provide your Medicare information and we will submit your claim.

Patients with Medicaid: We are not providers of Medicaid, and you will be responsible for your bill.

Returned checks: Returned checks will be subject to a $25 fee. We do not accept temporary or post-dated checks.

Collection fees: If it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred.

Minor patients: The parent or guardian accompanying a minor is responsible for the payment of services. Regardless of insurance coverage, young adults (age 18 and over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement.

Divorced parents: The parent who brings the child to the appointment is deemed responsible for payment, regardless of who provides insurance coverage. Our office will not become involved in disputes over which parent is the responsible billing party.

I have read, understand and agree to the above terms and conditions, I authorize my insurance company to pay my benefits directly to St. Louis County Oral & Maxillofacial Surgery.

Patient name _____ Date_____

Signature of Patient or Legal Guardian/Parent_____