

GULF COAST ORAL & FACIAL SURGERY
FINANCIAL POLICY

Your health and well-being are our primary concern. We feel that we provide the highest quality of Oral and Maxillofacial Surgery available to our patients. Therefore, we feel it is important for our patients to fully understand their treatment plan, the fees involved and the method of payment. In order to avoid any misunderstanding, we wish to explain our office policy regarding the payment of fees.

OUR OFFICE POLICY REQUIRES THAT PAYMENT OF FEES BE MADE IN FULL AT THE TIME OF SURGERY OR TREATMENT.

The following are accepted methods of payment:

1. CASH OR DEBIT CARD-CHECK (requires valid photo ID)
 2. VISA, MASTERCARD, DISCOVER, OR AMERICAN EXPRESS
 3. CAPITOL ONE, CARE CREDIT, OR WELLS FARGO (ASK TO APPLY)
 4. ASSIGNMENT OF INSURANCE BENEFITS (SEE BELOW)
1. Written pre-authorization of benefits covered by your insurance can usually be determined. It takes approximately four to six weeks to obtain written pre-determination of benefits covered. Any charges **NOT COVERED** by your insurance would require payment in full before services are rendered. Some insurance companies will not assign benefits. Those companies have been identified and **require full payment prior to surgery**.
 2. **NOTE:** If your insurance plan requires a referral, it is your responsibility to obtain it from your primary care physician. If a referral is required and we do not have it on file, then you will be responsible for the visit in full, and co-pay will not be accepted.
 3. This office cannot accept responsibility for collecting your insurance claim: therefore, if payment is not received from your insurance company within 60 days from the date of service performed, you are responsible for paying the balance owed. You will receive a statement once your insurance has paid their portion, or if no payment is received you will receive a statement after 61 days. All accounts with outstanding balances 120 days after date of service will be turned over for collection.
 4. This office will not get involved in child custody issues. The parent or guardian who signs the financial policy will be responsible for the balance owed.

I hereby assign all medical-surgical and dental benefits, including major medical benefits to which I am entitled, to Gulf Coast Oral & Facial Surgery. This includes Medicare, Medicaid, private insurance and any other health/medical plan I have. This includes services rendered to myself and/or my covered dependents. Payment will be directly paid to Gulf Coast Oral & Facial Surgery. I understand that I am responsible for any amount not covered by my insurance. A photocopy of this is to be considered as valid as the original. My signature below signifies my acceptance of these terms.

Signature _____ Date ____/____/____

NOTE: FOLLOW-UP VISITS WILL BE INCLUDED WITH SURGERY FEES UP TO A CERTAIN POINT DEPENDING UPON THE SURGERY. FOR CLARIFICATION, PLEASE FEEL FREE TO INQUIRE.

****IF THERE ARE ANY BILLING ISSUES WHICH NEED TO BE RESOLVED, PLEASE CONTACT OUR FINANCIAL MANAGER FOR ASSISTANCE.**