Patient Name: _____ Date: _____

PSS Oral & Maxillofacial Surgery

Financial Agreement

Dear Patient/Guardian,

This letter sets forth our office financial payment policy.

I understand that as a recipient of dental care I, the undersigned, am responsible for all charges regardless of my circumstances of reimbursement. Full payment is due at the time of delivery of service. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate the doctor for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for services provided, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc).

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to H. Paul Casmedes, DDS, MD or PSS Oral & Maxillofacial Surgery all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility.

Patient balances are due immediately and not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances. Should I fail to pay unpaid charges for more than 120 day my account is referred to a collection agency.

I acknowledge that I understand when a patient No shows, cancels or reschedules more than twice a minimum fee will be required to be paid prior to future appointments to be scheduled. The fee will be determined based on my insurance contracted rate or the self-pay fee and the type of appointment needing to be scheduled.

Payment may be made with cash, check, or credit card (discover, visa, master card and American express). There will be a service charge for a returned check.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing this office with complete and accurate billing information, including, but not limited to, a current insurance card and authorization numbers. I am responsible for all visits and procedures not properly authorized.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit unless otherwise arranged prior to the visit.

I give my consent to provide dental care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED (patient or guardian)_____DATE_____

FOR (printed patient name)_____