



## Financial Policy

Thank you for trusting Crystal Coast Oral & Facial Surgery to provide your medical/dental care. Our staff is committed to providing you with the best quality care while making your visit a comfortable experience. As a part of our service, we try to minimize the cost of your care. In an effort to do this, we have implemented the following Financial Policy.

### Payment Policy

-Patients with no insurance are expected to pay in full at the time services are rendered. If you have dental insurance (Other than United Concordia), we factor in your benefits as a courtesy. However, **you are responsible for the full amount of your estimated portion prior to surgery.** (If the patient is not financially responsible for the account, we can accept payment from the responsible party the day of surgery.) **Insurance quotes are only an estimate and any amount not covered by insurance is the patient's responsibility.** (For patients with United Concordia insurance, the company pays based on their allowance. We require payment in full and the insurance company will send you a direct reimbursement for anything they do cover.)

-We accept cash, CareCredit, debit and all major credit cards. **We DO NOT accept checks.** If you have questions about our fees for our services, please do not hesitate to ask before the service is performed.

-Adult patients are responsible for full payment (aside from insurance estimated coverage) at the time of service. Adults accompanying patients who are minors are responsible for the full payment (aside from insurance estimated coverage) at time of services for the minor.

### Insurance Policy

-As a courtesy to our patients, we will file claims on your behalf to one medical and two dental policies. Any additional filing will be the responsibility of the insured.

-You are financially responsible for the estimated portion not covered by your insurance company and **the total amount must be paid prior to the day of surgery.** (If the patient is not financially responsible for the account, we can accept payment the day of surgery from the responsible party.) Please be aware that your insurance company may not cover some services and that your insurance company may pay less than the estimated amount for some services. If your insurance company pays less than the estimated amount for your services, you are responsible for the remaining balance.

-**The total balance is your responsibility whether your insurance does or does not pay.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and are not responsible for the amount your insurance company pays for our services. We must rely on our patients to understand their insurance coverage. The insurance payment estimates that we provide are only estimates. We have no control over what your insurance company decides to pay for the services. Please make sure to provide us with all of your insurance information so that we may assist in getting your claims paid promptly.

### Finance and Billing Charges

-Any charges incurred to collect payments on delinquent accounts will be added to the account balance and billed to the responsible party on that account.

### Cancellation & "No Show" Policy

-Two missed appointments will result in dismissal from the practice. **There will be a \$50.00 cancellation or "no show" fee for all surgical procedures that aren't cancelled within 48 hours of the procedure.** Surgeries scheduled in the surgery center/hospital setting that aren't cancelled within 24 hours of the procedure will be charged a \$150.00 cancellation or "no show" fee. (These fees will not be applied toward your surgery/procedure and will be added as a charge to your account, not billable to insurance. The patient is unable to reschedule their surgery until the fee is paid in full.) **One "no show" surgical appointment will be grounds for dismissal from the practice.**

**I understand and accept the terms of Crystal Coast Oral & Facial Surgery's financial policy.**

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_