Oral & Maxillofacial Surgery

Howard D. Klein, D.M.D.

OFFICE FINANCIAL POLICY

It is the policy of this office to make payment arrangements at the time of the office visit. This may be handled in one of the following ways.

1. If you are here for a consultation, payment for the office visit and any x-rays is expected today. The fee for any indicated surgery will be discussed with you.

2. If you have dental insurance, payment of your deductible and your portion of charges (the co-payment) is expected at the time services are performed. We will call your insurance company to verify your coverage and collect information regarding your anticipated coverage benefits. We will refund any overpayment to you or send you a bill for any underpayment. All insurance claims must be settled within 60 days of the surgery, otherwise you will be held responsible for payment of the entire bill. Remember information obtained from your insurance company only provides an estimate.

3. If you do not have dental insurance, payment in full is expected at the time of surgery. In addition to cash and checks, we also accept Visa and Mastercard. We also offer no interest payment plans using Care Credit and American General Finance. If interested in these, ask at the time of the consultation.

4. A charge of $25.00 will be added for each returned check.

5. All amounts not paid within sixty (60) days after day of treatment will be considered in default and subject to certain delinquency charges, which I agree to pay. It is understood by me that should my account be turned over for collection, then I will be responsible for collection costs, including reasonable attorney's fees. This may be as much as an additional 50% of the delinquent amount.

6. We welcome and encourage frank discussion of services and fees prior to treatment in order to avoid misunderstandings.

I have read and agree to comply with the above office financial policy.

_____ _____

Signature Date

I authorize the release of information regarding examination or treatment related to this claim and permit any payment to be made directly to Dr. Klein of any benefit due.

_____ _____

Signature Date