FINANCIAL POLICY

Please read carefully and sign:

Basic Financial Policy: Payment in full for services rendered. We accept cash, check, debit cards, Mastercard, Visa, Discover, and Care Credit.

I fully understand and agree that I am responsible for the payment of this account. All accounts over 90 days are subject to a 2% monthly (annual percentage rate of 24%) service charge. I understand if this balance is not paid in full within a reasonable amount of time, (90 days or less); East Tennessee Oral & Maxillofacial Surgery (ETOMS) has the right to take legal action. In the event this account is involved in litigation I expressly waive any objection to venue and set venue may be Blount County, Tennessee or county of choice. I understand I will be responsible for additional costs incurred should collections become necessary. I, the responsible party, agree to pay these costs which can include court and/or attorney fees PLUS an additional 40% for collection agency fees. I authorize ETOMS' collection agency to obtain my credit report from any of the three major reporting agencies. If I have any questions or concerns or if I require other financial arrangements I will ask before treatment is rendered. When applying for credit, I authorize release of any employments records to ETOMS and authorize ETOMS to access necessary credit information.

Minors: The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Care Credit, Visa, MasterCard, Discover or payment by cash or check at the time of service.

Patients with Insurance: As a courtesy to our patients, we do accept assignment of benefits and will bill your insurance carrier if proper paperwork is provided. Patients without proper insurance identification will be considered private pay and will be responsible for their balance on the day of service. It is the patient's responsibility to provide us with correct billing information. Incorrect information may cause delays in payment of your account. We will expect you to begin making "good faith" payments in the event your insurance processing goes over 90 days due to incorrect billing information given on the day of service. It is our policy to collect all co-pays and deductibles on the day of service. We do our best to determine what your insurance will pay, but this is not always possible. You may owe an additional balance, or we may owe you a refund.

Some benefit plans require pre-authorization and a specialist referral form from the primary care physician. It is your responsibility to know your insurance requirements. It will be helpful for you to call your insurance company prior to your appointment day to determine if you need any prior authorization.

It is your responsibility to know if your dental plan has a maximum payout per year and to know how much of this you have used for the year. (Some plans have a $1,000 max. and some may have $1500 - $2000 max. per year).

Workman's Compensation: We require the necessary insurance billing information and employer authorization.

Personal Injury Cases: This office does not accept liens nor bill auto accident, liability or lawsuit-related cases. The patient is responsible for payment at the time services are provided.

Divorced Parents: We will be glad to bill the responsible parent for your child's account. However, both parents are responsible for a minor child's bill, and both parents will be held accountable. We are not a party to your divorce decree. It will be up to the parents to determine "who owes what."

Insurance Waiver: I have been informed by East Tennessee Oral and Maxillofacial Surgery that the service rendered on this date may be denied by my insurance carrier as medically unnecessary or as services not covered by the plan provisions including, but not limited to, denials due to plan maximums or limits. I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR THESE SERVICES.

SERVICES: ESTIMATE OF CHARGES:

My signature certifies that I have read and understand the financial policy of East Tennessee Oral & Maxillofacial Surgery. I authorize the release of any medical records or other information necessary to process my insurance claim(s). I authorize payment of benefits, otherwise payable to me, directly to the provider of services listed on claim(s).

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Signed Name **Date**