BEDFORD
ORAL SURGERY

OFFICE FINANCIAL POLICY

Please read this Office Policy sheet carefully. If there is anything you do not understand about our policy for payment and assistance with insurance processing please ask.

Please contact your Human Resources department if you have any questions or complaints about benefits provided by your insurance. They need to know.

Obtaining reliable financial information from insurance companies regarding oral surgery procedures is difficult. Contract allowances have many conditions for eligibility established by the insurance carrier not based on the need for the service.
These conditions for eligibility change and we are not apprised of the changes.

Treatment Fee and Payment:

- ✓ Payment is expected at the time of treatment.
- ✓ Financial arrangements can be made in advance of your appointments.
- ✓ Estimated payments are due at the time of your appointment.
- ✓ Pretreatment estimates can be submitted to your insurance company so that they can provide you with financial information regarding the amount they will or will not pay towards the above treatment. **Any quotes are ESTIMATES only**. We will do our best to help you with insurance information from your insurance company.
- ✓ An insurance handling fee of $25.00 may be charged to your account if additional filling is required for coordination of benefits.

- ☐ I understand that ESTIMATES of insurance benefits for services performed both verbal and written are **only ESTIMATES.**
- ☐ I understand that this office attempts to obtain information about **YOUR BENEFITS as a courtesy to you.**

- ☐ **I understand that any information this office provides you regarding benefits coverage is not a guarantee in any respect that the insurance company will pay this amount.**
- ☐ **I will not hold this office responsible for benefit information obtained on MY behalf. The information may not be accurate. Ultimately this information is your responsibility, we are only assisting you.**

- ☐ All balances are due in full 90 days after treatment *regardless of insurances intent to pay.*

- ☐ **I understand that my dental insurance carrier and or medical insurance carrier may pay less than the actual fee and or estimate for services provided in writing or verbally. ALL estimates are nonbonding. I agree to be responsible for payment of all services rendered on my behalf of my dependents.**

Authorization and Release:

_____ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or other health practitioners.
_____ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
_____ I authorize release of payment and claims information by my insurance company to Dr. Baldassarre. Patient or

Guarantor Signature: _____ Date: _____