

# CROWLEY ORAL SURGERY AND ASSOCIATES

## PATIENT PAYMENT POLICY

Please read the following information carefully. Patient or guardian signature is required before treatment commences.

Our patients are special to us; we care about you. Your dental health and your financial responsibility is our concern as well as yours. Our payment policy is explained below in order to help you easily understand it.

If we are in network and/or providers with your insurance companies, today may only be a certain percentage of the total fees or a co-pay on your insurance card. This is not a guarantee of payment from your insurance company. If insurance does not pay the remaining balance on your account, this balance will become a patient balance, and you will receive a bill. For those patients covered by insurance, we will be more than happy to assist you in filing your insurance claim form. However, insurance rarely pays the entire total, even if your policy states that you have 100% coverage.

If we are out of network and/or not providers with your insurance companies, we will collect total procedure fees in full. We can still submit claims to your out of network insurance companies for you. Please be aware, insurance companies may pay less to an out of network provider, than they would to an in network provider. Any payment by your insurance companies for procedures that have been paid in full by the patient, you will be reimbursed by our office.

If you prefer to delay your treatment, we will request a pre-determination of payment from your insurance company. This pre-determination may take up to 4-6 weeks. At the time of your future procedure, you will only be required to pay the amount not covered by your particular insurance plan.

Any separated or divorced parent accompanying a dependent child for treatment is considered to be legally responsible for this patient.

Overdue account balances will be subject to 1.5% monthly interest charge (18% annual), and further action will be taken on overdue accounts. The under-signed also agrees to pay reasonable attorney's fees in the event that this matter is assigned for collection.

**IF TODAY IS A CONSULTATION:** When possible, and as a service for our patients, we will attempt to verify your insurance coverage prior to your next appointment. The total due on the day of surgery is only an estimate and not a guarantee of your exact insurance coverage nor payment. Any balance remaining after your insurance company has made payment, is your responsibility.

### **Authorization to Release Information:**

I hereby authorize the above named facility to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used exclusively for the purpose of evaluation and administrating claims for benefits.

All payments are ultimately the responsibility of the patient or guardian.  
Our experienced staff is here to help you in any way possible.

---

**Patient or Parent/Legal Guardian Signature**

**Date**