Oral Surgery Associates of Paris Financial Policy
Please read carefully and initial

We accept cash,personal checks, cashiers checks, money orders and credit cards.
___ The fees quoted are an estimate. If the procedure proves to be more or less complex than anticipated, the fees will be adjusted accordingly.
___ The quoted fees will be honored for a period of 60 days.
___ There is a $50 fee for returned checks.

Missed or Cancelled Appointments

___ In an event of a no show or cancellation within 24 hours (24) notice, there will be a $75 dollar missed appointment fee added to treatment for each missed visit.

For Dental insurance coverage - *please review carefully*

___ Dental insurance is an agreement between you and your insurance company for you to pay certain amounts for surgical care. <u>You are responsible for any and all charges that are not paid by your insurance carrier after 45 days of non payment.</u>

___ Insurance information must be presented at least 48 hours prior to appointment for verification otherwise out of pocket fees will apply until coverage is confirmed.

___ We will require your estimated share of the surgical fee prior to time of service. This estimated share is based on information obtained from your insurance carrier and is not a guarantee of payment by them. Occasionally, the insurance carrier may provide inaccurate or incomplete information to us when making an estimate.

___ As a courtesy to our patients, we are happy to file your dental insurance claims for you and work on your behalf to secure reimbursement for up to 45 days from the date of service. Response times vary greatly amongst insurance carriers

___ Any balance will then be due forty-five (45) days later, regardless of any insurance payments that may yet be received by this office. Once insurance payment is received, we will inform you within 1-2 business days whether a refund for balance is on the account.

For all surgical procedures performed at our office

___ We request payment one week prior to each planned procedure date.
___ For Dental implants, our fee will cover routine care from the time of the first procedure and for one (1) year following the final restoration of the implant, as long as all pre-operative and post-operative recommendations are followed.

For Minors under 18 years told

___ For minors, the parent/guardian bringing a minor to an appointment and signing treatment plan is responsible for any balances due regardless of insurance guarantor. In cases of divorce the same applies to unpaid balances. The office will not involve itself in personal family disputes.

Credit Options

We do not offer in-house lending programs, however we do partner with third party lenders to assist you in managing treatment fees. Please feel free to ask one of our patient coordinators for more details. All payment is due prior to time of service. Prepayment is certainly accepted.

I give my permission for this office, their staff and agents, to contact me via any means provided in the patient information form regarding my care and account. My signature below indicates that I have read and/or had explained to me the above statement, that I understand it, and that I agree to all the conditions stated above.

______________________________ ______________________________
Patient/Caregiver Date

Best Contact Number ______________________________

Oral Surgery Associates of Paris
Medicare Private Contract Opt Out Notice

By signing this contract I understand and agree that I will not submit (or request that my oral surgeon submit) a claim to Medicare or its agents for services provided by Dr. David Martinez even if such services would otherwise be covered. I agree to be fully responsible, through insurance or otherwise, for payments of services rendered by Dr. David Martinez and I understand that no claims will be submitted by our office to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral surgeon for services provided. I understand that Medicare plans do not, and other health and medical insurance plans may elect not to make payments for such services.

I understand and have the right to have services provided by other oral surgeons or other practitioners for whom Medicare payments would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted out.

I understand Dr. David Martinez is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective April 30th 2022 and will expire April 30th 2024.

Patient Name: ____

Date: ____

Patient Signature: ____

Oral Surgeon's Signature: __________________________________