Northtowns Oral and Maxillofacial Surgery, PLLC
FINANCIAL RESPONSIBILITY STATEMENT

TO OUR PATIENTS (Please read in its entirety):

The doctors and staff at Northtowns Oral and Maxillofacial Surgery are dedicated in providing oral and maxillofacial surgery procedures in a caring and comfortable environment. We want to be sure that all of our patients receive the care and attention that they deserve. We also want to be sure that each patient understands our office policies and procedures including our financial policy. Please feel free to ask us any questions if you are unclear about what is stated below.

The dental insurances we participate in are Delta Dental and Cigna PPO.

The medical insurances we participate in are Medicare and Univera, which includes Seniorchoice and Independent Health. If your plan requires you to pay a co-payment or co-insurance, we ask that you pay that at the time of service. The amount due will be determined by contacting your insurance company.

If you have any other dental insurance, we ask that you pay for services in full at the time they are rendered, and then, we will gladly submit your claim to your insurance company so that they may promptly reimburse you.

All services will be billed to the responsible insurance company. If for any reason the claim is rejected, you will be responsible for payment. **After the insurance payment is received, any balance that is the patient's responsibility is due immediately upon receipt of a bill.** Also, please be advised that the parent bringing a child in for treatment is responsible for payment at the time of service regardless of personal circumstances.

We are sensitive to the fact that it may be difficult for all patients undergoing more extensive and costly procedures to pay at the time of service. If this situation pertains to you, or if you are uninsured, we do offer third party financing through CareCredit. Our staff will be happy to explain how this works when you come in for your consultation visit. If you would like to obtain information about CareCredit prior to your visit, please feel free to visit their website at www.carecredit.com

I authorize payment directly to Northtowns Oral and Maxillofacial Surgery, PLLC for services rendered unless otherwise payable to me under the terms of my insurance. I agree to all terms listed and stated above. I understand that in the case of non-payment, that I will be responsible for any collection and/or attorney fees that may be involved in the collection of my debt.

Please be advised that failure to show for a surgery appointment will result in a $100 no show fee, and failure to show for a consultation appointment will result in a $25 no show fee. Please provide our office with 48 hours' notice cancellation if you are not able to make your appointment. Thank you for your cooperation!!

Signature: _____Date: _____

Print Name: _____Relation to Patient: _____