Northtowns Oral & Maxillofacial Surgery, PLLC
FINANCIAL RESPONSIBILITY STATEMENT

TO OUR PATIENTS (Please read in its entirety):

Dr. Glen Donnarumma and the staff at Northtowns Oral & Maxillofacial Surgery are dedicated to providing oral and maxillofacial surgery procedures in a caring and comfortable environment. We strive to ensure that all of our patients receive the care and attention that they deserve. We would like each patient to understand 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.

Dental/Medical Insurance – We do not directly participate in any dental or medical insurance plans; however, our staff will be happy to work with you on optimizing your insurance benefits. We ask that you pay for services at the time they are rendered, and we will gladly submit your claim to your insurance company so they may reimburse you for covered services. ***The only exception is for a medical claim to Medicare and/or Medicare Advantage plan due to our "Opted Out" status with Medicare as neither the provider nor the patient can legally submit a bill to Medicare for reimbursement***. If you have any questions, please let the staff know and they can review this with you.

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. Whoever is signing this form must be present at the time of appointment and no digital signatures will be accepted.

The staff at Northtowns Oral & Maxillofacial Surgery 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. Please note that we only offer the 6 month no interest plan. 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 & 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 of cancellation if you are not able to make your appointment.

Thank you for your cooperation!

Signature: _____Date: _____

Print Name: _____Relation to Patient: _____