Coastal Oral & Maxillofacial Surgery Center
Financial Policy

Welcome to our office. We thank you for selecting our office to take care of your dental/medical needs. We value our patients greatly and we want your experience here to be genuinely pleasant and professional.

We require all patients/guardian to supply a picture ID and valid insurance card at the time of service.

Our office consultation fee/co-payment is due at the time of service. We will gladly file your insurance for reimbursement and any overpayment will be applied to your surgery fee. _____ *(initial)*

At the end of your consultation appointment, each patient will be given a proposed treatment plan. The proposed treatment includes the fee for surgery, the ***estimated*** *insurance reimbursement, and the* ***estimated*** *patient share.* _____ *(initial)*

*Our office will contact your insurance company to verify eligibility and an estimated percentage of coverage. However, if the insurance pays less than the quoted estimate, the patient is responsible for payment on the balance immediately.*_____ *(initial)*

Please be informed that we are happy to assist you by filing an insurance claim for reimbursement. However, the patient/guardian is responsible for any and all balances due on the account if the insurance fails to pay within 60 days _____ *(initial)*

The patient/guardian will be responsible for all costs if the account is placed with a collection agency. _____ *(initial)*

Authorized Signatures:

_____ _____

Patient *Date*

_____ _____

Parent/Guardian *Date*