CHERRY TREE ORAL AND MAXILLOFACIAL SURGERY

JAY E COWAN, D.D.S.

Thank you for choosing my practice for your oral surgery needs. I am committed to providing you with the best overall possible care. This includes proper and timely handling and filing of your insurance claims. However, you must realize your insurance is a contract between you, your employer and the insurance company. It is your responsibility to furnish complete insurance information at the time of your appointment. Without the complete insurance information, we will be unable to properly file your claim and therefore, you will be responsible for the entire bill at the time of your appointment. ***While our office will provide accurate information to your insurance company for processing your claim, we look to you for payment for our services and we are not obligated to pursue or prosecute any claims or disputes you may have with your insurer.***

__(initial)

Insurance companies pay a percentage of the "Usual and Customary" charges. These fees do not always match the doctor's fees; therefore, we will provide you with an **estimate** of what the insurance will cover and what your surgery deposit will be. This deposit will be due the day of surgery. The surgery deposit is only an ESTIMATE. If your insurance pays more than quoted to you, we automatically refund to you any overpayment. If the insurance pays less, you will be billed for the remaining balance. **____ (initial)**

Regardless of insurance coverage, account balances which are 90 days or over from the date of service, payment will be expected in full by the person who signed financial responsibility for the account. If you have any questions regarding this policy, please feel free to speak with us. **___ (initial)**

In consideration of the services provided to the patient, I/we hereby guarantee payment in full of the patient's account within thirty (30) days from payment of insurance. I/we agree that in the event of default in payment, I/we will also be responsible for and pay all reasonable attorney fees, court costs and expenses incurred in the collection of sums due hereunder, together with a finance charge of eighteen percent (18%) from the date hereof on any such amount placed for collection. Any patient payments that are turned over to collections will have a collection fee equal to (30%) of delinquent balance plus any applicable attorney and or court fee.

___(initial)

CANCELLATION POLICY: To avoid a $50.00 charge, a 48-hour notice is required for cancellation of your scheduled appointment. **___ (initial)**

Patient Name (print) _____

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

Our office honors the HIPAA Privacy Act.

I _____, Date of Birth: _____, requests the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include my name, diagnosis(es), test results, dates of service, procedures performed, and pre-op and post-op information.

PLEASE CHECK ALL THAT APPLY

___ You may disclose information to my family members and/or non-family members listed below:

Name: _____, Phone #_____Relationship _____
Name: _____, Phone #_____Relationship _____

___ You may leave Protected Health Information on my answering machine/voicemail/cell.
Phone #: _____ Cell #: _____

My signature below is acknowledgement of receipt of "NOTICE OF PRIVATE PRACTICES" (and on request can been given a copy of the office's Privacy Practices) and I also understand the above section, where I have initialed, that I am responsible for this entire account, not my insurance company, although the insurance may pay a portion of the fee charged.

X_____ _____
PERSON FINANCIALLY RESPONSIBLE SIGNATURE DATE