Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from **South Texas Oral Surgery** . The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.southtexasoralsurgery.com or on request from our staff.

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Financial Policy

Thank you for choosing our office as your dental health care provider This statement is to inform you of your financial policy. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health. We wish to inform you of our office policy in this regard. Our financial policy is intended to facilitate excellent service specific to your treatment while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as a dental provider, our relationship is with our patient not the insurance company. As a courtesy to all of our insured patients, we will file your dental insurance claim forms. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. We ask that you pay the deductible and co-payment, which is the estimated patient portion or amount not covered by your insurance carrier at the time of service. We emphasize this is only an **estimate** and all charges you incur are your responsibility. Insurance companies have a wide variety of rules, plan limitations, and exclusions that our office may not be aware of. Not all services are covered benefits in all contracts. *It is your responsibility to thoroughly understand the coverage and expectations of your particular policy.* Your claim will be filed immediately and benedits are expected to be paid within 30-45 days. If the claim is not cleared in 60 days, the unpaid portion will automatically become “self-pay” and a statement will be issued. You are responsible for amounts not paid by your insurance company chooses not to pay.

Outstanding balances are discouraged and must be paid upon receipt of a statement & cleared before your next appointment. **Delinquent balances** over 90 days will be referred over to a Collection Agency & a 30% fee will be added to your account. Your account will become “Inactive” and will remain “Inactive” until paid in full, including collection fee. **A Return Check** fee of $35.00 (subject to change as bank fees increase) will be added to your account for any returned check. Any future visits will have to be paid in cash, VISA, Mastercard, Discover, Amex, or Carecredit.

We do ask for payment at the time of service. We do accept Check, Cash, Visa, Mastercard, Discover, Amex. We do accept Carecredit and offer no intrest payment plans up to 12 months. We do not accept payment plans.

I understand and accept *the financial and the dental insurance policies listed about and have had any and all questions answered to my satisfaction.* ***I agree*** *to pay for all treatment in a timely fashion as described so as to avoid any additional fees.*

Signature____ Date____