Metro Oral and Maxillofacial Surgery
FINANCIAL POLICY

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, debit cards, and credit cards (Visa & Mastercard). Due to the large number of returned checks, we are no longer accepting personal checks.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will verify insurance benefits and collect what your insurance will not pay on the day of surgery. Every effort will be made to closely **ESTIMATE** your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. **We will make every effort to contact you by phone with an ESTIMATE but it is ultimately your responsibility to contact our office if you have not heard from us before your surgery. PLEASE UNDERSTAND THAT INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full by you. You will be responsible for outside lab services. The lab will send a separate statement.

MANAGED CARE PARTICIPANTS: Some benefit plans require pre-authorization and specialist referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary to process your claims on the day of consultation. All co-payments or patient out-of-pocket fees are due and payable at the time of service.

SURGERY FEES: All co-payments, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. (To assist our patients, we offer alternative financing sources. Please inquire with the patient representative.)

WORKERS COMPENSATION: If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

PERSONAL INJURY CASES: This office does not accept liens nor bill for auto-accident or other liability or lawsuit related cases. The patient is responsible for services provided at the time of service.

CANCELLATION OR NO-SHOW APPOINTMENTS: Please give **24-hour** notice if you are unable to keep your appointment. A **$100.00** fee will be charged for any broken surgical appointment not canceled 24 hours in advance. The practice reserves the right to dismiss patients with excessive cancelled appointments.

SIGNATURE ON FILE: I request payment of authorized insurance benefits to be made on my behalf to **METRO ORAL & MAXILLOFACIAL SURGERY** for services provided me by listed facility and/or physician.

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PATIENT'S/LEGAL GUARDIAN SIGNATURE DATE

I understand that if my account becomes delinquent it will be placed with **Prim and Mendheim LLC**. I also agree and consent to the following terms regarding any outstanding balance that I owe: (1) I will incur interest on the balance due at the rate of 1 and ½ percent per month (18% PER ANNUM); (2) I will be responsible for reasonable collection costs and attorney's fees in and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding any outstanding balance and/or debt that I owe, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive all rights to claim exemption. I affirmatively consent to and agree not to claim any and all personal property, homestead, and /or wage exemptions, in particular that certain wage exemption contained in article X of the State of Alabama Constitution of 1901, that I may be entitled to, whether the said exemption be statutory and/or constitutional in nature, and waive any and all defenses thereto. I further agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida, I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time my balance has not been paid as I have agreed herein that my credit history will be investigated and thoroughly reviewed. By signing below, I consent to the foregoing terms and affirmatively acknowledge that I have read, or have been provided adequate time to read, the foregoing before signing below.

PRINT PATIENT NAME DATE

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

RESPONSIBLE PARTY SIGNATURE DATE