ArcherPeak Oral and Maxillofacial Surgery
Office Financial Policy

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks, and credit cards. For any delinquent accounts, a collection charge of 50% will be added to the balance.

CHECK ACCEPTANCE POLICY: We accept personal checks with a valid picture ID. If you choose to pay by check and your check is dishonored, you agree to pay a processing fee of $40, or any higher amount allowed by law, and we may electronically debit or draft your account for this fee. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment.

FOR PATIENTS WITH DENTAL INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your **primary** insurance carrier, provided proper paperwork is provided to us in advance. Every effort will be made to closely **estimate** your co-payments and deductibles, which are due at the time of service, **but ultimate responsibility for the unpaid balance rests on you.** 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 from you. Any service provided that is under $300.00 must be paid at the time of service. In cases where we accept "assignment of benefits," we will require a 30% down payment.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality care at a reasonable cost to our patients. In fairness to other patients, and the doctor, we require at least 24 hours notice when canceling an appointment. There is a $100.00 fee for missed appointments without 24-hour notification, which will be due and payable from you. The practice reserves the right to dismiss patients with excessive cancelled appointments.

I understand that my signature requests payment to be made and authorize release of medical information necessary to pay the claim.

Patient's Name (please print) _____

Responsible Party's Signature _____

Social Security Number _____ Today's Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above dental entity.

Signed (Insured) _____ Date _____