ARBOR VIEW
ORAL & FACIAL SURGERY

INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to Arbor View Oral & Facial Surgery (AVOFS). This form is designed to help you understand dental insurance, payments and financial responsibility of the patient, as these can all be complicated.

To begin, we would like to highlight a common misconception. Dental insurance was not designed to pay off **all** dental care costs. Most contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary, are governed by the premiums paid and nothing to do with the actual charges. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract. Our fees are based on information given by the American Dental Association in relation to this location. However, it should be understood that the dental insurance contract is between the insurance company and the policy holder. The patient/guarantor bears the ultimate financial responsibility.

As a courtesy, we will bill your insurance company for all services rendered. However, be aware that the patient/guarantor is responsible for any deductible and/or coinsurance on the day that services are rendered. Once insurance has made any payment, you will receive a patient statement for the balance due or a refund if one is owed. It is expected that this payment will be made within thirty (30) days. If payment is not received, it will be considered **past due** and may be sent to collections.

Notice of Financial Responsibility

With my consent, AVOFS may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such users and disclosures. You may review the Notice of Privacy Practices prior to signing this consent.

With my consent, AVOFS may call and leave a message on voicemail or in person in reference to any items that assist AVOFS in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to clinical care and/or payment.

With my consent, AVOFS may mail to my home or other designated location any items that assist AVOFS in carrying out TPO, such as appointment reminder cards and patient statements.

Payment for Service: I understand I am responsible for paying the full amount for all services and providing at least one form of credit or debit or ACH information for payment for all amounts due. If I am insured, I authorize AVOFS to release all information necessary to secure payment. I further understand my share of the cost of the services, e.g., co-payments, co-insurance, and deductibles, will be collected utilizing my form of payment provided.

Insurance Claims: As a courtesy, AVOFS will file insurance claims with your insurance carrier. Your insurance company, in lieu of reimbursing you directly, will pay AVOFS any benefits for services rendered. Your insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of all services rendered. You are responsible for making available complete insurance information for accurate filing of claims. To meet this end, we will request your current insurance card at each visit. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is your responsibility to know and understand your insurance coverage. Not all services are a covered benefit in all contracts. Additionally, some services we provide will be billed separately for the office visit and may require separate co-pay or be applied to your co-insurance/deductible. Please call your insurance company to verify your benefits. You will be responsible for all fees not paid by your insurance company.

Financial Assistance: For patients with financial need, we offer payment plans and financing options. Please ask to speak with one of our financial representatives to discuss the available options.

Unpaid Account Balances: In the event that you fail to make payments for services rendered or an reason, your account may be turned over to a collection agency. You will be responsible to pay the collection agency's fees that may be incurred in the collection of any outstanding balance.

Agreement: I have read the above form and policies and agree to the terms stated.

Name (printed)

PATIENT'S OR LEGAL GUARDIAN'S SIGNATURE

Date

See Reverse Side for Terms & Definitions

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Surgical Appointment Deposit Policy: A non-refundable deposit of 25% is due to schedule and secure your surgical appointment. The remaining total of your procedure will be due on the day of service when treatment is rendered.

Missed Appointment Fee: To maintain the continuity of a valuable and busy surgical schedule, patients who cancel their appointment with less than 48 hours notice will be charged a $50 fee for a consultation and $150 for a surgical appointment. This fee must be paid before a new appointment is scheduled. Patients with three (3) missed appointments will be asked to transfer their records to another doctor.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining if. Failure to obtain the referral and /or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate of 1% to the overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of your suit, you agree the venue shall be in Cook County, Illinois.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Credit History: In the event we do not receive payment, you give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transfer of Records: You will need to request in writing and pay a reasonable copying fee if you would like to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Workers Compensation: We require written approval/authorization by your employer and/or Workers Compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.