FINANCIAL POLICY

Thank you for choosing Stamford Oral and Maxillofacial Surgical Arts! Our office is committed to providing you with the best possible care. After consulting with our Board Certified Oral and Maxillofacial surgeons, you can decide whether the proposed treatment is right for you. Regarding the financial aspects of your treatment, we have established the following policy to assist you in better understanding and managing your financial responsibility.

Our office accepts the following forms of payment for services rendered: Cash, Check (payable to SOMSA) & credit cards: American Express, Discover, MasterCard, and Visa. It is our policy to charge a $50.00 fee for all returned checks. An optional financing plan is also available via CareCredit Healthcare Financing. Important: Please provide us with both your dental AND medical insurance information. Oral surgery procedures may be covered by dental and/or medical insurances, depending on your coverage. It is your responsibility to ensure that your insurance policy if effective on the dates of service. If you are a patient of record, please advise us promptly of any changes in your address, health status or insurance information.

Patients without dental insurance at the time of service:

If you don't have dental insurance, payment in full is expected at the time of service.

Patients with dental insurance at the time of service:

We are in-network dental providers with the following Dental Insurance Plans:

Dr Edibam: Delta Dental Premier & PPO, MetLife and Cigna DPPO.
Dr. Case: Delta Dental Premier & PPO and Cigna DPPO

(Please note: we are NOT in network with Cigna Advantage PPO plans. It is not always clearly marked on your card, so please go online to Cigna member benefits to confirm)

We are NOT contracted providers for any medical insurance companies, including Medicare or Medicaid. Even if you have dental insurance, we reserve the right to collect payment in full at the time services are rendered (such as for implants, CT scan, cyst removal etc), and occasionally, prior to service. Dental/Medical Insurance is a contract between your employer or yourself and an insurance company. Benefits received are based on the terms of the contract chosen. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your policy so that you are fully aware of coverage and limitations of your benefits. We are happy to answer any questions you may have. Please be aware that some procedures may not be covered (sometimes considered NOT medically necessary) by your insurance carrier. If we participate with your insurance plan at the time services are rendered, the treatment fees that

PLEASE TURN OVER…..

you owe will be at the contracted rates. We will file your in-network or out-of-network **dental** insurance claim as a courtesy. We will file the medical claim only for in network patients, and only if it is relevant to the procedure, or if required by your dental insurance company. We are unable to file all other medical claims, including those for Medicare or Medicaid. We are happy to provide you with codes of the treatment provided at the office if needed. It is your responsibility to follow up on any pending claims directly with your insurance companies. Most insurance companies will respond within 4 to 6 weeks with an Explanation Of Benefits ("EOB"). Sometimes, depending upon the procedure, we are required by insurance companies to file a medical claim first, and once processed, we send it to dental insurance. Once the insurance payment has been received by us, we will update your account and send you a statement for the balance owed. If there has been an overpayment by you, we issue you a refund check which is mailed out monthly. This can take up to 60 days or more, due to the complex nature of insurance claims.

Outstanding Balances:

If after reasonable efforts are made to collect your payment for outstanding bills, and if the account still has an unpaid balance at the 90-day mark, we reserve the right to turn the account over to a Collection Agency. In the event an account is turned over to a Collection Agency or Attorney, the patient or person responsible for the patient's account agrees to pay a collection, court costs and any other reasonable costs of collection. For all billing and payment inquiries, please contact our office at 203-325- 2661.

I have read, understand and agree to the above financial policy of Stamford Oral and Maxillofacial Surgical Arts LLC. I understand that it is my responsibility to pay any fees owed to Stamford Oral and Maxillofacial Surgical Arts. This signature on file is also my authorization for the release of all information necessary to process any insurance claims in order to secure maximum benefits on my behalf. I hereby authorize insurance payment to Stamford Oral and Maxillofacial Surgical Arts. I understand I am responsible for all charges, whether or not paid by the insurance company unless dictated by the insurance company that there is a contractual write off.

Patient Name: _____ **Date** _____

Signature of Patient / Legal Representative: _____

Relationship To Patient: _____

MISSED APPOINTMENT/SURGERY POLICY

At Stamford Oral and Maxillofacial Surgical Arts, we understand that emergencies occur. However, to best serve patients at our Surgical Office, we take cancelled appointments/surgeries seriously, as the doctor sets aside time to see you, often special supplies are pre-ordered, instruments are prepared, and time is blocked out for your surgery. To be fair to all our patients, we ask that you check your schedule in advance and make all necessary arrangements so that you can be at our office at your scheduled time. If you are running late, please call to inform us. We genuinely appreciate your understanding and cooperation! For all scheduling, billing & payment inquiries, please contact our office at 203-325-2661.

I, _____ **(Patient Name), agree to the following:**

- If I miss a **scheduled appointment** (including consultations, CT scans etc), and do not provide 24 hours notice during working hours to Stamford Oral and Maxillofacial Surgical Arts, I understand I will be billed and responsible for a $50.00 missed appointment fee. (Post-operative checks are excluded).

- If I miss a **scheduled surgery at the office** (including tooth extractions, implants, bone grafts, sinus lifts, jaw surgery etc) and do not provide 24 hours notice during working hours to Stamford Oral and Maxillofacial Surgical Arts, I understand I will be billed and responsible for at least 30% of the total surgery amount on that same day. If I subsequently undergo the surgery on a rescheduled day at this office, that amount will be applied towards my procedure. If I do not undergo the procedure on another day, the fee is non-refundable.

If after reasonable efforts are made to collect your missed appointment/surgery fees, and the account still has an unpaid balance at the 90-day mark, we reserve the right to turn your account over to a Collection Agency. In the event an account is turned over to a Collection Agency or Attorney, the patient or person responsible for the patient's account agrees to pay collection, court costs and any other reasonable costs of collection.

I have read, understand and agree to the above Missed Appointment/Surgery policy of Stamford Oral and Maxillofacial Surgical Arts. I understand that it is my responsibility to pay any fees owed to Stamford Oral and Maxillofacial Surgical Arts.

Signature of Patient / Legal Representative: _____

Relationship To Patient: _____Date _____

Consent to Dental Photography/Videography & Authorization of use of Patient X-rays/Photographs/Videos

I, _____, hereby authorize Stamford Oral and Maxillofacial Surgical Arts, LLC and its assignees to take & use photographs/video/audio of my face/jaws/teeth, before, during and after treatment. I understand that these are very useful in treatment planning/tracking.

Please initial one box regarding the use of photos/x-rays/scans/videos:

☐ I consent to allow the photographs/x-rays/scans/videos to be used and shared in variety of situations including but not limited to educational/training/marketing purposes. I am aware that if used, ***my name will be kept confidential***.

____ I ***agree*** to have my entire face shown, along with my teeth/smile/mouth/jaw area when shared.

____ I ***only*** **agree** to have my teeth/smile/jaw area shown without any identifying features when shared.

This authorizes Stamford Oral and Maxillofacial Surgical Arts, LLC. and/or any of their assignees to take and use photographic/audio/video/material of me that can be used in a variety of communications, including educational purposes, training of dentists/doctors, social media posts, website publications, medical and general interest publications, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines). I release Stamford Oral and Maxillofacial Surgical Arts and its employees and legal representatives from any and all claims, actions and liability relating to its use of said materials.

OR

☐ I do ***not*** agree to the pictures being used for any purpose other than my treatment plan, and I only agree to them being shared with those individuals involved with my treatment plan.

- I waive any right to inspect or approve any works that may be created containing the said materials. I understand and agree that Stamford Oral and Maxillofacial Surgical Arts, LLC is and shall be the exclusive owner of all right, title, and interest, including copyright, in the Materials, and any advertising or promotional materials containing the Materials released hereunder.
- I understand that if I wish, I can revoke/withdraw this consent at any time to prohibit future use of my information. To do so, I must send written notice, sent by registered mail to Stamford Oral and Maxillofacial Surgical Arts, LLC, 27 Bridge Street, Stamford, CT 06905. I understand that revocation affects disclosure moving forward and is not retroactive. If not revoked/withdrawn by me, this authorization expires 99 years from the date that I sign it.
- I understand that Stamford Oral and Maxillofacial Surgical Arts, LLC does not and cannot condition treatment on whether or not I sign this authorization.
- I do not expect compensation, financial or otherwise, for the use of these photographs.
- I am aware that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other versions as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.
- I have fully read this release and understand that signing this release is voluntary and not a condition of employment. I am fully familiar with its contents, and hereby agree to the terms hereof as of the date indicated below.

I have read, understand and agree to the above.

Signature (Patient): _____Date:_____

(For minors under 18 years of age, a parent or guardian must sign)

Parent/Guardian Name: _____ Relationship:_____

Parent/Guardian Signature:_____ Date: _____