# ORAL & MAXILLOFACIAL ASSOCIATES
# Financial Policy

Dear Patient:

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

- Payment for services is due at the time services are rendered.
  - We accept cash, checks, Visa, MasterCard, Discover and American Express.
  - We will be happy to assist you with applying for financing should you so desire. We do not handle any financing "in house" but we do have financing available through "Care Credit" and "Unicorn."
  - We reserve the right to collect before services are rendered.

- All charges are your responsibility whether the insurance company pays or not.
  - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
  - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
  - If your insurance company does not pay your claim within a reasonable time frame, we may require you follow up with your insurance and/or pay the balance due.

- Unless you are insured by Medicare (medical claims only) or an insurance group which our doctors are participating members, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered.

- If you are a member of an HMO or Managed Care Program or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit.
  - We will make every effort to assist you, however, the responsibility is yours and without an authorization number, your visit will need to be rescheduled.

- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems, so that we may assist you in the management of your account. You may reach an Account Manager at (405) 848-7999.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

_____ _____

Patient's or Guarantor's Signature Date

_____ _____

Witness's Signature Date