MIDDLETON ORAL SURGERY
FINANCIAL POLICY

Patient Name: _____ DOB: _____ Date:_____

Here at Middleton Oral Surgery, we are committed to providing you with the highest standard of oral surgery care. We welcome you and your family into our practice and we strive to make your personal experience positive and pleasant. In order to achieve these goals, and focus on caring for you, we need your assistance in understanding our financial policy.

- **Payment of fees:** I understand that I am responsible for payment in full on the day services are rendered.
  We accept Visa, MasterCard, Discover, American Express, Care Credit, checks, and cash.

- **Responsible party policy:** Parents or legal guardians bringing a minor into the office will be expected to pay in full on the day services are rendered. In the event that parents are divorced or separated, the person who brings the minor in for services is financially responsible for all monies owed on the day services are rendered.

- **Surgical appointment policy:** In order to reserve your surgical date, we require 50 percent of your financial estimate to be paid at the time of scheduling your surgery. On the date of your surgery the remaining balance will be due in full.

- **Appointment policy:** We require a 24 hour advance notice to reschedule or cancel your appointment. If you no-show or cancel your appointment without a 24 hour notice we reserve the right to charge you for the missed appointment at the rate of a normal office visit. We respect your time and appreciate your understanding that the doctor has reserved time specifically for your appointment.

- **Insufficient Funds:** In the event your payment is denied due to insufficient funds, your account will incur a 10% finance charge and a $50 insufficient funds fee that will be auto billed on the credit card that is kept on file.

- **Unpaid insurance balances:** I understand that a monthly finance charge of 5% will be added to any unpaid insurance balance over 30 days. If we are contracted with you dental insurance you are required to provide a credit card to keep on file for any unpaid balance over 30 days. You will be notified in writing of any charges. If you decline keeping a credit card on file you will be responsible for paying for your services in full at the contracted rate. We will file the dental claim for you and any insurance reimbursement will be payable directly to you. We strive to provide you and your family with prompt, high-quality care and appreciate your understanding that payment is due in a timely manner.

Name on Credit Card: _____ Credit Card type: _____

Credit Card on File: _____ Exp Date: _____

Security Code: _____ Billing zip code: _____ Today's Date: _____

Signature: _____

*****I authorize this credit card to be kept on file and billed for any balance after 30 days*****

I acknowledge that I have read, understand, and agree to abide by the financial policies of the office:

Signature: _____ Date: _____

Relationship to Patient: _____