Excellence in Oral & Maxillofacial Surgery, LLC

Thank you for selecting our practice for your healthcare services. We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can sometimes be. To begin, we would like to highlight a 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 (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality surgical care. 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.

However, it should be understood that the dental insurance contract is between the insurance company and the policy holder (patient), and the patient/guarantor bears the ultimate financial responsibility.

As a courtesy to you, we will bill your insurance company for all services rendered, however, please 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.

If you do not have insurance or if you have an insurance policy that Dr. James Vetter is not contracted with, please be advised that it is our office policy to request payment in full at time of service. We will be happy to assist you by submitting all insurance paperwork on your behalf with payment reimbursement to you directly.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our team for clarification on services, billing, or insurance.

Please acknowledge your understanding of this notice and your willingness to comply with the above by signing below.

Patient/Responsible Party Signature Date

Authorized Signature for Office Date

Please turn over for more information and initials

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 El Paso County, Colorado.

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

Missed Appointment Fee: The second time a patient does not show up on time for and appointment, or cancels with less than 24 hours notice, a $20 fee will be charged. 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.

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.

INITIAL_____DATE_____