BILLING POLICIES & PROCEDURES CONTRACT

***We make every effort and pride ourselves on being error free during the billing process, however, an occasional mistake may be made when preparing your walkout bill, interim statement(s), or final statement(s). If you notice a mistake, please point it out to us and we will correct it. Once any billing errors or mistakes are corrected YOU WILL BE RESPONSIBLE to pay the corrected balance, whether it is HIGHER or LOWER.**

***Any accounts going into collections will be assessed all collection fees and court legal fees and 21% annual interest until paid in full.**

***A $30.00 fee will be charged to your account in an event where any check has been returned by the bank.**

***If you fail to appear for a surgical appointment without at least a 48-hour notice there will be a $350.00 cancellation fee charged to your account.**

***I understand that I am responsible for all office charges. I understand that I must pay my agreed upon treatment fee in full at the time of treatment.**

***We will make every effort to help you receive insurance reimbursement through your carrier(s), however we cannot guarantee what amount, if anything, they will pay, nor the time it will take them to process claims.**

By completing the credit card information form below I authorize Southern Ocean Oral Surgery & Implant Center to bill my credit card for any outstanding balance which still remains 90 days after treatment is rendered or after all insurance is exhausted, whichever is sooner.

Credit card type: Visa____ M/C: ____ Amex____ Discover____

Card Number: _____ Expiration Date: _____/_____

Name on Card: _____ Billing Zip: _____ CVV: _____

By signing below, you indicate that you have read, understand and accept all of our policies, procedures, and credit card agreement:

Responsible Party's Signature_____ Date: ____/_____/_____