Alamo Heights Oral Surgery, PLLC

Notice of Privacy Practices and Financial Policy

PATIENT NAME: _____ DOB:_____

Notice: During a visit to our office, patients may receive several different kinds of services; each one may have a separate charge.
(Please Initial Below)

_____ ITEM 1- Consent to Treat

I hereby authorize/consent Alamo Heights Oral Surgery, PLLC and its surgeons to treat me/my child.

_____ ITEM 2-Assignment of Insurance Benefits

I hereby authorize and assign, my insurance carrier(s), to make payment directly to AHOS of insurance benefits for services herein specified and otherwise payable to the insured. AHOS files primary insurance as a courtesy to patients. I understand and agree that I am financially responsible to AHOS for all charges incurred regardless of potential insurance benefits, including but not limited to Co-payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand AHOS will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company that the surgeon(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

_____ ITEM 3- Requirements at Time of Service

I understand insurance cards must be presented at time of service or patient will be self-pay until cards are presented or if insurance changes within treatment, cards must be presented before AHOS will file claims to new insurance. Co-Payments, Co-Insurance, Deductibles and Non-Covered services are due at the time of service. I understand my insurance company may require a referral before being seen. If not obtained I will be responsible for incurred charges until a referral is obtained. I understand a current (within the last 6-12mos) panoramic film will be needed to provide an appropriate diagnosis and ensure insurance coverage, if applicable, or I will be responsible for the fee for a new one. I understand that I will receive a billing statement after insurance has paid in full. After 60 days, unpaid balances may be transferred to a collection agency with an additional rebilling fee of $25.00.

_____ ITEM 4- Minor Patients (Patients under age 18)

Any patient under the age of 18 must be accompanied by a parent/guardian to each visit. I understand by signing AHOS' financial policy, I am solely responsible for any incurred charges for the below named patient. Patient's under the age of 18 may not cancel or change an appointment in this office.

_____ ITEM 5- Payment Options

I understand that AHOS accepts payment in the form of credit card, cash, checks and care credit. Payment is due the day of service.

_____ ITEM 6- Noncompliance

I understand AHOS has the right to discharge any patient from this practice at any time due to non-compliance. If this occurs, records will be released to a physician of my choice only when a signed release of information is received in this office.

_____ ITEM 7- Appointments

I understand if I do not notify AHOS **at least 24 hours in advance** to cancel an appointment there will be a **$100.00 cancellation fee.** I understand that if I arrive 15 minutes or more late for an appointment, I may be asked to reschedule my appointment.

_____ ITEM 8- Housecalls

I understand AHOS may call the patient's home and/or leave a message to confirm the appointment date, time, location, or any applicable medical instructions. In addition, I understand AHOS may leave a detailed message on my telephone number relating to any lab, x-ray results, and instructions for dental care. I also understand AHOS may send any written communication to my home address

_____ ITEM 9- Notice of Medicare Opt Out

I understand this is a "private contract" between AHOS and I with regard to the patient's agreement to pay AHOS' fees in full at time of service which might otherwise be paid for by the Medicare Program. I understand AHOS has elected to opt-out of the Medicare Program and are unable to file claims to Medicare and neither can I. I accept full responsibility for payment of the Dentist charge in full at the time of service. I understand that Medicare limits do not apply to what the Dentist may charge for services.

_____ ITEM 10- Notice of Privacy Practices

I acknowledge that I have read and/or received a copy of AHOS' Notice of Privacy Practices.
Please List Persons to Whom Protected Health Informations May Be Released :

_____

Patient's Signature _____ **Initials** _____ **Date** _____

Guardian or Other Responsible Party _____ **Initials** _____ **Date** _____

Alamo Heights Oral Surgery, PLLC

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At Alamo Heights Oral Surgery, PLLC, we make every effort to provide you with the finest surgical care and the most convenient financial options. To accomplish this, we will work with you to maximize your insurance reimbursement for covered procedures and find a payment option that works best for you.

Payment Responsibility
It is your responsibility for all charges incurred, regardless of insurance coverage.

Payment Methods
We offer the flexibility of Cash, VISA, Mastercard, Discover, American Express or payment by check. We partner with Carecredit to help you obtain a line of credit. You can apply at www.carecredit.com to get pre-approved prior to your scheduled surgery.

Evaluation Fees
Our surgeons perform an evaluation prior to your treatment. This evaluation may occur at a separate appointment. Please be aware that there are fees associated with your evaluation/consultation that may not be covered by your insurance. Not performing an evaluation prior to treatment might compromise your care.

Initial Payments
If you are covered by insurance, you are required to pay a portion of your total expenses. This initial payment is due on the day of your surgery. Your insurance company may require you to make additional payments. If there is no insurance coverage for your surgery, payment in full is required on the day of your services performed.

Medicaid Patients
Medicaid pays us directly for your care. You are responsible for any charges not covered by Medicaid.

Medicare Patients
Medicare does not cover any of our services. You are responsible for the charges.

Insurance
As a courtesy, we will file your insurance claims for you, provided that you supply us with complete and accurate information. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to know your plan(s) benefits, if any, and to pay any deductible, co-insurance or any balance not paid by your insurance company.

You may have benefits for your surgery through your medical and/ or dental insurance, or no coverage at all. Because of this, we ask you to call your insurance company prior to surgery to verify your benefits (i.e. deductibles, limitations, exclusions, and yearly maximums)

If your insurance company does not process your claim within 60 days, you may be billed directly for the full fee. To ensure prompt processing, we encourage you to check the status of your claim with your insurance company. Please note that insurance is a contract between you/your employer and the insurance company. We are not a party to that contract. You are fully responsible for all fees and charges, regardless of your insurance company.

Estimates
An estimate of the charges for your surgery will be given to you upon request. This is an **estimate only** and does not ensure your exact amount due for our services after insurance pays. You will be billed for any remaining balance. A current X-ray is necessary for us to give you a complete estimate of our fees. Some insurance plans allow a pre-determination to be processed prior to treatment, generally processed within 3-6 weeks. Although not typically mandatory, your specific insurance plan may require a prior authorization; it is your responsibility to inform us so we can assist you in this process.

Payment Arrangements and Collections
If you are unable to pay in full, payment arrangements may be approved in accordance with credit and collection procedures as authorized by our Financial Coordinator. We are happy to say we currently do not place a finance charge on overdue balances. However, if your bill is not paid in full after 90 days, your delinquent account will be sent to an outside agency for collection. You may be responsible for all collection costs, attorney fees, court costs and your credit score may be negatively impacted.

Refunds
Overpayments will be refunded to the appropriate party. Patient refunds will not be processed until all insurance processing is finalized. Refunds less than $5.00 will be issued upon request.