CAROLINA ORAL & FACIAL SURGERY, P.A.
FINANCIAL POLICY

Thank you for choosing Carolina Oral & Facial Surgery for your oral surgery needs. Our office is committed to providing you with the best possible care. You are the single most important person making decisions regarding your health. After consulting with us, you ultimately decide whether a treatment is right for you. We have developed the following policy to assist you in understanding and managing your financial responsibility.

If services rendered total $300.00 or less, the patient is responsible for payment in full. If charges exceed $300.00, 50% and any unmet deductible and co-insurance must be paid at the time services are rendered. The following exceptions apply:

- **If a patient has Guardian, Blue Cross / Blue Shield medical, Blue Cross / Blue Shield State (medical and dental), Blue Choice, or Delta Dental Federal, payment in full is due when services are rendered.**
- **Carolina Oral & Facial Surgery is not a contracted provider for Tricare medical.**
- **Blue Cross / Blue Shield dental patients will be required to pay 75% of their bill at the time services are rendered.**
- **Delta Dental Premier patients will pay the percentage due under their contract plus deductible. Carolina Oral & Facial Surgery is only contracted with the Premier plan under Delta Dental.**
- **In the event, a patient does not have insurance; PAYMENT IN FULL is expected at the time services are rendered.**

As a courtesy to our patients, we will be happy to submit your insurance claims, x-rays and any other necessary information relative to treatment. However, since our professional services are rendered to you and *not* to the insurance provider, you are directly responsible to us for your financial obligations. After, your insurance company has made payment on your account any refunds will be issued to you within 7 to 10 business days after receipt of payment.

Once the insurance payment has been received, if a patient's account is not paid within 45 days, the account will be placed with a collection agency. Accounts are subject to a $5.00 monthly service charge. In the event an account is turned over to a collection agency or attorney, the patient or person responsible for the patient's account agrees to pay a collection, court costs and any other reasonable costs of collection. For billing and payment inquires, please contact our business office at 864-458-9800.

Insured Adult Children: I am responsible for informing my parent(s) of the proposed surgery and financial arrangements.

□ I authorize Carolina Oral & Facial Surgery to send financial and surgery information to the insured parties.
□ Do not send any information.

If I miss a scheduled appointment, and do not provide 24 hours notice to COFS, I understand I will be billed and responsible for a $75.00 missed appointment fee.

To the extent to determine liability for payment and to obtain reimbursement, I, the responsible party, authorize disclosure or portions of the patient's record. I hereby assign all medical and / or surgical benefits, to include major medical / dental benefits to which I am entitled, including MEDICARE, PRIVATE INSURANCE, WORKERS' COMPENSATION, and other health plans to Carolina Oral & Facial Surgery, P.A. This assignment applies to all charges outstanding as of the date of this signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am responsible for all charges whether or not paid by the insurance company unless dictated by the insurance company that there is a contractual write off. **I hereby authorize said assignee to release all information necessary to secure payment.**

I have read and understand the financial policy of Carolina Oral & Facial Surgery for _____ .
Patient Name

Signature of Patient / Legal Representative _____ Relationship To Patient _____ Date _____