EXCLUSIVE ORAL SURGERY, LLC

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Wayne, NJ 07470
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Written Financial Policy

Thank you for choosing Exclusive Oral Surgery. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:
You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please remember that the contract itemizing your dental/medical benefits is between you, your employer and your insurance carrier. Also, dental and/or medical insurance plans are not designed to cover all of your dental/medical needs. Rather, the amount your dental/medical plan contributes towards your dental/medical is based on the plan selected and purchased by your employer. Regardless of your coverage, any "per office visit co-pays," deductibles, or "per service co-pays" that you, as the patient, are responsible for, are due in full the day of treatment.

If after claim submission, your dental and/or medical insurance company does not pay for any reason within the usual and customary time frame of 60 days of treatment, or is denied by your insurance company for any reason, you will be responsible for the outstanding balance, and you will need to seek reimbursement from your insurance company.

EXCLUSIVE ORAL SURGERY, LLC has received by Explanation of benefits via a telephone call to my insurance company. Information received is subject to change and ideally EXCLUSIVE ORAL SURGERY, LLC recommends a written pre-authorization for the treatment scheduled to be performed. EXCLUSIVE ORAL SURGERY, LLC has not filled/received the recommended pre-authorization for the scheduled work. I have elected to begin treatment without this written approval. I am aware that I will be responsible for the office fee of $___________ should my insurance deny treatment, or if I have exceeded my yearly maximum benefit. If treatment is approved, I understand that I may still have a co-payment due.

Remember, the financial break-down is an estimated treatment obligation based on a telephone conversation with your insurance company. The reference # for that conversation is ___________________________________. During the course of the treatment, other procedures may be indicated, and occasionally, complications arise that dictate additional procedures or treatment. You will always be advised of these charges.

I, _________________________________, have read, understand and accept full financial responsibility for this account, and for all services performed upon myself/dependent at EXCLUSIVE ORAL SURGERY, LLC. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that EXCLUSIVE ORAL SURGERY, LLC cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by EXCLUSIVE ORAL SURGERY, LLC is not a guarantee of insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. I also agree to pay the greater of either a finance charge of 1.5% per month on any balance due over 30 days or $100.00, as well as collection, court costs, attorney fees and interest fees accrued with the collection of this account.

_______________________________   _______________________
Patient, Parent or Guardian Signature   Date