Appalachian Oral Surgery Center – Financial policy

Utilizing Insurance: Please keep in mind that your insurance policy is a contract between you, your employer, and the insurance company. We must emphasize that as dental care providers, our relationship is with you, not with your insurance company. While the submission of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility at the time of service. It is the responsibility of the patient to provide us with the following information for a claim to be processed:

(1) ***Patient's driver's license***
(2) ***Patient's DOB and Social security number***
(3) ***Dental insurance information***
(4) ***Medical insurance information***
(5) ***Policy holder's DOB and Social security number***

We strongly encourage you to read your policy so that you are fully aware of coverage and limitations of benefits since AOSC is not a party within your contract.

Once your claim is processed, you will receive a check from your insurance company. If the check comes to AOSC, we will contact you directly to verify a mailing address to send the check to you. Any insurance benefits are based on the terms of the contract you chose. Any payment that you receive from your insurance company is based on your policy.

x _____

Scheduling Surgery: A ***non-refundable*** deposit of $100 or $200 (*depending on your treatment*) is required to secure time with our surgeon to treat your clinical needs. This deposit will be applied to the total treatment amount at the time of surgery. We require you to arrive 15 minutes prior to your scheduled surgery so it can start on time.

Surgery with Sedation: Your surgery will be cancelled for your safety should you arrive ***without a responsible driver, or ate/drank within the last 8 hours***. A new ***non-refundable*** deposit will be collected to reschedule your surgery.

Due to the increased number of patients seeking surgical care in the community, please notify the office ***no less than 3 business days*** prior to your appointment to reschedule without requiring a new non-refundable deposit.

*****Two consecutive cancelled appointments will result in dismissal from the practice*****

x_____

We accept ***cash, check, all credit cards, and care credit.*** There will be a ***$100 fee*** on all returned checks.

Costs pertaining to your treatment must be paid prior to being processed.

I have read, understand, and agree to the above terms and conditions provided by Appalachian Oral Surgery Center.

Patient or Guardian name (printed):_____ **DOB:** _____

Patient or Guardian name (signature): _____ **Date:** _____

All estimates are applicable for 30 days from the date of the signed document

8-22-2019