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# San Diego Center for Oral and Facial Surgery

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## Fee Agreement and Information About Insurance (Please Read Thoroughly)

Patient Name: \_\_\_\_\_

Guarantor (person financially responsible): ( ) self ( ) father ( ) mother ( ) other: \_\_\_\_\_

Your pre-treatment estimate contains information about the procedures that have been recommended to you by your doctor and the approximate costs of those procedures. The actual costs of the procedures recommended to you may be more or less depending on a variety of factors that include but are not limited to findings during surgery, materials used, and length of surgery. We make every effort to predict your surgical outcome so that your pre-treatment estimate is as accurate as possible.

Utilization of insurance benefits to cover the costs of services rendered can be a very complex process. It is important for patients to understand that an insurance plan is a contract between the patient and the insurance company and that payment for services rendered is ultimately the patient's responsibility. Therefore, it is very important for the patient to fully understand the rules of their insurance policy and what their insurance policy will and will not cover prior to having any procedures performed. Because the process of utilizing insurance benefits can be complicated, our office will assist you in every way possible to clarify your insurance coverage and to maximize your insurance benefits. In most cases, it is impossible to determine exactly what your insurance plan will cover at the time of your consultation without a predetermination of benefits from your insurance company. That being said, a predetermination of benefits does not always guarantee payment from your insurance company.

Depending on your insurance plan, a 10% - 40% down payment (your estimated portion) is payable on the date of surgery. We will bill your insurance for the date(s) of service for the amount billed to you. Depending on your coverage, plan limitations, deductible, or use of your yearly maximum, you may or may not have a remaining balance after your insurance has paid their portion. If for any reason your insurance fails to pay their portion within 90 days, the balance due will be your responsibility. If your insurance pays their portion and this leaves a credit balance on your account, you will receive an appropriate refund from our billing office within 4 weeks of insurance payment. You will receive a monthly statement from our office keeping you apprised of your account status until your account is paid in full.

For patients without insurance, full payment is requested on the date of service; however, financial arrangements can be made if needed. If you do not provide us with a current and valid copy of your insurance card(s) you will be considered a cash patient and payment will be due at the time of service.

If you are a college student age 19 years or older and are claiming full-time student status for insurance coverage purposes, then it is your responsibility to provide our office with current student status documentation at the time of service. This documentation is necessary to process your insurance claim and can be obtained from your school's registrar's office. Our office is not responsible for any delay in payment or lack of payment from your insurance company due to the lack of student status documentation.

Many procedures performed in our office are elective in nature. These procedures include but are not limited to dental implants, bone grafts, and cosmetic and reconstructive facial surgery. Although certain elective procedures may be necessary for your overall health and well being, insurance companies, in general, offer very limited or no coverage for these types of procedures. Patients should be fully prepared to accept financial responsibility for elective procedures.

Our office does not accept Medicare, Medi-Cal, Denti-Cal, Blue Cross, Blue Shield, or Tricare (medical only) insurance. We do not accept personal checks over \$500.00. All major credit cards are accepted.

By signing below, you are indicating that you are the responsible party and the guarantor for either your account or this patient's account and that you have fully read and that you fully understand and agree to the above.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date