

Little Neck Bay Oral and Maxillofacial Surgery

Financial Policy

We are delighted to welcome you to our practice and we are pleased that you have chosen us to serve your oral and maxillofacial needs. The following is a statement of our financial policy which we require you to read and sign at the bottom of this page.

Payment is expected at the time that services are rendered and is the responsibility of the individual signing this agreement.

Payment methods: we accept all major credit cards, care credit, cash as well as participate in major insurance plans

Dental Insurance

We are pleased to participate with several insurance providers directly-please verify with our staff if you are not sure if your insurance provider is included. In general, we will accept any insurance that will pay us directly. What your insurance doesn't pay is the patient/parents/legal guardian's responsibility. We do not participate with any HMO/DMO or Medicaid plans.

An estimated co-payment is requested from you at each appointment as services are rendered. This is determined by your benefits within your plan, not our office.

Please understand that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles their claims or for what benefits they allow on a claim. We can only assist you in estimating your portion of the fees. We cannot guarantee that your insurance will pay for each claim nor can we assume responsibility for the accuracy of any insurance information. It is your responsibility to understand your insurance policy and terms.

You are responsible for payment of any balance due not paid by your insurance company including unpaid deductible amounts. Although we try our best to estimate as accurately as possible, the final amount your insurance will actually pay isn't determined until they issue a claim check to us.

Missed Appointments

We ask for your utmost courtesy regarding your scheduled appointments. If you are unable to keep your appointment please allow at least 24 hours prior to appointment time if you must cancel or reschedule. We understand that unforeseen emergencies do occur, however, we reserve the right to charge a \$25.00 fee for repeated last minute cancellations or broken appointments.

By signing below, I understand and agree to this policy

Patient/Parent/Legal Guardian_____Date_____