MID-PENN ORAL SURGERY, LLC

Dr. Donald J. Dinello, DMD

MID-PENN ORAL & MAXILLOFACIAL SURGERY

Dr. Jeffrey L. Rajchel, DDS, MS

OUR OFFICE AND STAFF CANNOT GUARANTEE YOUR ELIGIBILITY AND INSURANCE COVERAGE. IT IS RECOMMENDED THAT YOU CONTACT YOUR INSURANCE COMPANY DIRECTLY TO CONFIRM COVERAGE AND ELIGIBILITY. ANY INFORMATION PROVIDED IS STRICTLY AN ESTIMATE BASED ON INFORMATION PROVIDED BY YOUR INSURANCE COMPANY.

OUR FINANCIAL POLICY

We are committed to providing the best possible care and are happy to discuss our professional fees at any time. Your clear understanding of our financial policy is very important. If you have any questions about our fees, financial policy or your financial responsibility, please ask!

If you do not have insurance coverage, our office requires payment in full at the time of service. We accept cash, check, VISA, MasterCard, American Express, Discover, and CareCredit. Please be advised that all payments made by personal check will be deposited electronically. For any returned check, a $30.00 service fee will be charged.

YOU ARE RESPONSIBLE FOR THE PROMPT PAYMENT OF YOUR ACCOUNT. Payment is due at the time of service, unless other financial arrangements have been previously made with our office.

HIPAA

I hereby acknowledge that I have received or have been offered a copy of this office's Notice of Privacy Practices as is required by law.

CANCELLATIONS OR MISSED APPOINTMENTS

Due to the amount of time allotted for scheduled appointments, we request at least 24 hours' notice (1 business day) for cancellation. It is our policy to charge $100 for a surgical appointment and $40 for a consultation appointment if proper notice is not given. This fee must be paid prior to being able to reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

REGARDING YOUR INSURANCE

If you have insurance, our office will submit your claim as a courtesy to you if you have provided our office with all necessary information. **IT IS YOUR RESPONSIBILITY** to verify your benefits and confirm that the coverage is active for the date of service. Insurance coverage is an agreement between **YOU** and **YOUR INSURANCE COMPANY**. We will not become involved in any disputes between you and your insurance companies other than to supply necessary information. In the event of non-payment, you may be required to pay your bill during the appeals process and await reimbursement from your insurance. Additionally, we will not submit a claim to your insurance company for any non-covered services. it is your responsibility to confirm that your insurance company processes and issues payment within sixty (60) days. If payment has not been received within ninety (90) days from the date of service, the balance of the account will become your responsibility. By signing this form, you hereby authorize Mid-Penn Oral Surgery to submit a claim to your insurance company for all eligible services and authorize payment of all benefits to be issued directly to Mid-Penn Oral Surgery.

FINANCIAL RESPONSIBILITY AGREEMENT

I have read the above FINANCIAL POLICY and understand that I am financially responsible for all services rendered, whether or not these charges are paid by my insurance. I understand and agree that a monthly finance charge of 1.5% will be added to my account balance if not paid in full within sixty (60) days by either myself or my insurance company. I further understand and agree that my account may be forwarded to the Credit Bureau for collection after ninety (90) days of patient responsibility, and that all previous adjustments will be reversed and a 30% collection fee will be added to my outstanding account balance.

Patient Name: ______________________________ Date: ______________

Responsible Party (Please Print): ______________________________
(if other than patient)

Responsible Party Signature: ______________________________
(Patients 18 and older are their own responsible party, unless there is a power-of-attorney.)