

Greater St. Louis Oral Surgery

Financial Policy

Thank you for choosing Greater St. Louis Oral Surgery to provide your oral surgery care. We are committed to providing the best quality care to each of our patients. Please understand that payment of your bill is considered a part of your responsibility in this relationship. The following is a statement of our Financial Policy to help you understand your obligation, which we require you to read and sign.

Regarding Insurance

All charges will be submitted to your insurance plan for which coverage exists. Copays and charges for services not covered by your insurance are due **AT THE TIME OF SERVICE**; this includes coinsurance and deductible amounts that are your responsibility.

Copays

Copays are a part of **YOUR** contract with your insurance company and by law are due **AT THE TIME OF SERVICE**. Insurance companies **do** perform random audits and if a breach of contract is found it may result in a loss of your coverage.

Trauma and Accident Related Injuries

This office does not accept assignment of benefits for charges related to accident or trauma. The patient/guardian is responsible for all charges at the time of service.

Minor Patients

The adult accompanying a minor patient (parent, legal guardian, grandparent, etc.) will be responsible for payment of the copay or any pre-determined charges not covered by insurance **AT THE TIME OF SERVICE**.

Adolescent Patients

Adolescent patients not accompanied by a parent are responsible for payment of the copay or any charges pre-determined not covered by insurance **AT THE TIME OF SERVICE**.

Separation/Divorce Policy

Greater St. Louis Oral Surgery is not a party to any separation or child support agreement or divorce decree. The parent accompanying the child is responsible for paying the copay or any charges pre-determined not covered by insurance **AT THE TIME OF SERVICE**. Balances for services denied by insurance are due in full thirty days after the date of the first monthly statement regardless of the terms of the separation or child support agreement or divorce decree. It is your responsibility to keep our office informed of any address, phone number, or insurance changes as we can only work with the information provided to us.

Rebilling Fees

A \$5.00 rebilling fee may be applied to balances \$20.00 or under not paid within ten days from the date of the first friendly reminder letter from the Billing Office. A \$25.00 service fee will be charged to your account for any returned checks. If two returned checks are received on your account within a twelve-month time period you will no longer be able to pay for services with a personal check. Payment will be accepted only by cash, money order, or credit card (MasterCard or Visa).

Thank you for understanding the need of a Financial Policy by our practice and assisting us in providing the best care possible. Please contact our office at (314) 721-1010, Monday through Friday 8:00 a.m. – 4:30 p.m. if you have any questions or concerns.

I, _____ have read the Financial Policy and I understand and agree to these terms,
Patient Name or Responsible Party
and to assignment of benefits from my insurance company to Greater St. Louis Oral Surgery.

X _____
Signature of Responsible Party

Date