NORTH JERSEY
ORAL & MAXILLOFACIAL SURGERY

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OUR FINANCIAL POLICY

Thank you for choosing North Jersey Oral & Maxillofacial Surgery as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance Form before seeing the doctors.

PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT ALL MAJOR CREDIT CARDS, CHECKS, AND CASH.

WE ALSO OFFER CARECREDIT®.

REGARDING INSURANCE

The balance of your account is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with complete and accurate insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do not accept assignment of benefits, we require that you make prior arrangements for payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical or dental insurances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

All patients are responsible for full payment at the time of services. The adult accompanying a minor is responsible for full payment. If payment is not received and collection proceeding occurs, you will be responsible for the 35% collection fee as well as any court costs and all attorney and legal fees incurred.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy; I understand and agree to this Financial Policy.

SIGNATURE OF PATIENT OR
PARENT IF PATIENT IS A MINOR: _____ DATE: _____

The patient is an adult, age 18 or over; however, I am assuming financial responsibility for them for any charges incurred at North Jersey Oral & Maxillofacial Surgery. I have supplied my driver license, and any bill incurred for services should be sent directly to me.

X _____ DATE: _____