Oral Surgery of Santa Fe

Financial and insurance Policy

Please sign and or initial all of the following disclosures:

_____ I understand that I am responsible for my bill and/or any amount not covered by insurance.

***Please be advised that some or all of the services may not be covered or considered necessary under your insurance policy. In these cases, you are responsible for payment of your account. We charge what is usual and customary for our area. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates.

Financial Policy:

_____ If the patient is a minor, our office policy is that both parents are equally responsible for all fees.

_____ Insufficient fund checks will be subject to a $35.00 returned check fee. Balances older than 60 days may be subject to additional collection fees and late charges of 1.5% per month

Insurance Authorization and Assignment:

***Insurance is a contract between you and your insurance company. We will be happy to assist you in filing necessary forms to help expedite insurance carrier payments. We will not become involved in disputes between you and your insurance company, other than to supply factual information as necessary.

_____ I hereby authorize the Oral Surgery Center of Santa Fe (Santa Fe Oral Surgery, LLC) to furnish information to insurance carriers concerning my illness and/or treatments, and I hereby assign the physician(s) all payments for medical and/or dental services rendered to myself of my dependents.

I have read, understand, and agree to the above financial and insurance policy.

Signature of Responsible Party _____ Date_____