Woodlands Oral & Maxillofacial Surgery, P.C.

TERMS AND CONDITIONS

MEDICAL AND SURGICAL CONSENT

All patient care is under the direction of the attending surgeon. You give consent for any medical or surgical treatment, x-ray examination, photography, anesthesia or hospital services rendered to the patient under the general and special instructions of the attending surgeon, consistent with your right to informed consent.

FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

You agree to pay our customary charge for professional services in full, at the time of service. We do not finance surgical fees.
Although insurance coverage has become an integral part of the financial planning of many people, most insurance plans reimburse only a fraction of the usual rate for services.
You understand that your insurance plan will reimburse only the amount to which you are entitled by your contract with them.
As a courtesy we may provide a co-payment estimate and may assist you in filing an insurance claim; but neither pre-authorization provided by your insurance plan, nor a co-payment estimate, are a guarantee of payment from your insurance plan.
Payment levels from your insurance plan are subject to change at their discretion, and may vary markedly from an initial co-payment estimate or pre-certification.
Any payment from an insurance plan is subject to your eligibility for coverage on the date the service was provided.

You are ultimately responsible for your account.
If payment is not received from your insurance carrier within 60 days after services are provided, you agree to immediately pay any balance due.
Furthermore, you hereby assign insurance benefits to which you are entitled to Woodlands Oral & Maxillofacial Surgery, P.C.

A consultation fee of $85.00 will be applied to your account at the initial appointment. Our panoral x-ray fee is $95.00.
A discretionary $75.00 fee may be applied for missed appointments and cancellations with less than 24 hours notice. Returned cheques are charged $40.00

The usual and customary rate that we bill to our patients is established according to criteria for reasonableness, which include: the time, labor and skills required for researching and rendering care; the difficulty, novelty or complexity of the problem presented; the resources consumed in creating the medical record and correspondence; and all costs advanced on your behalf. For substantial elective treatment we may require prepayment (a deposit).

Delinquent accounts increase our costs. To avoid burdening those who pay promptly, you agree to an interest fee of 24% of your outstanding balance added to your account balance 60 days after services were provided. Accounts that are delinquent 90 days will be forwarded to our attorney for collection.
Although we anticipate only an amicable relationship, in the unlikely event that we are required to institute a legal proceeding to collect fees and costs, the prevailing party would be entitled to reasonable attorney's fees and other costs of collection. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.
In addition, you agree that the sole place of venue for any legal proceeding or arbitration arising out of our relationship with you will be Coconino County, Arizona.

OWNERSHIP OF RECORDS

All patient records—including, but not limited to, notations, digital records, radiographs, photographs and models—are the property of the practice, although conditional access to records will be granted under applicable law. Access to records may only be granted by a specific and written request by the patient and/ or their legal representative.
Such access will not be reasonably denied during our normal business hours. A fee may be charged, at our discretion, for duplication and mailing of records.

PRE-AUTHORIZATION FOR SERVICE

If your insurance coverage requires pre-authorization prior to consultation or treatment, you understand that it is your responsibility to obtain and furnish to us the appropriate form authorizing the visit and/ or treatment.

PROVISION OF INFORMATION

You understand that information provided by you, the patient and/ or their responsible party, is relied upon to provide professional services.
Our high quality of care is possible only as complete and accurate information is provided.
You agree to furnish truthful and current information, and not to omit any information.

AUTHORIZATION FOR RELEASE OF INFORMATION

You hereby authorize us to furnish and receive information contained in the patient's medical record, including via phone, fax, mail, encrypted or unsecure email.
This information may be provided to any health care professional involved directly or indirectly in the patient's care; and is for purposes to include, but not be limited to, diagnosis of medical conditions, ordering of additional tests and educational purposes.
This information may be provided to a 3rd party (an insurance company, billing intermediary, or government agency) only if you direct us to file a claim for reimbursement with this 3rd party, or if required by applicable law.

LEGAL RESPONSIBLE PARTY

If the patient is a minor or under custodial care, you represent that you are legally authorized to obtain medical services for the patient.

I have read the above and agree to the terms and conditions as stated.

Patient Name	**Signature of Patient / Parent (if a minor) / Guardian / Legal Representative**	**Date**