BAN
Oral & Facial
Surgical Associates

Financial Agreement

FEES:

We ask that you be prepared to pay the reviewed charges applicable, at the time the services are rendered. This is subject to change based off insurance estimates that we provide as a service to you. These fees may also change depending on any other services that may have been used with your insurance for the calendar year. If you do not have insurance, your out-of-pocket expense may be subject to change due to changes in treatment.

INSURANCE:

If you have insurance, please have all information ready to give to us. We will need any primary and secondary insurances, along with the information of the policy holder. All referrals that you may need, insurance cards proving coverage, and coverage information are your responsibility to present to us so that we can be sure your treatment is covered.

Even though an insurance claim is filed, you are responsible for making sure your balance is paid within the limits of our credit policy. This office cannot accept responsibility for negotiating a settlement with your insurance company.

The extent of your benefits and coverage, will be determined by your insurance company. All co-payments, deductibles, and non-covered procedures are your responsibility and are payable to our office. If you have any questions or problems, be sure to let us know before the day of your surgical appointment.

HMO'S/PPO'S ETC: Please supply us with your card and referral form. Services cannot be performed without a referral from your primary care physician.

RETURNED CHECKS: There will be a $20.00 office charge plus all bank charges on any checks returned for non-payment. We will be happy to discuss any of these payment methods with you.

- For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time. Deposit for appointment may be required day of scheduling.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I understand that estimated treatment plans may change, and that I will be responsible for the work completed.

Patient/Guardian Patient Signature: _____ Today's Date: _____

OVER

BAN
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HIPPA Agreement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.
The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.
We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change this Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Patient/Guardian Patient Signature: _____ Today's Date: _____