OFFICE POLICY CONCERNING PROFESSIONAL FEES AND INSURANCE

The doctors and staff of Valley Oral and Maxillofacial Surgery are committed to deliver optimum health care for you and your family. We have made available to you the following options for payment:

* Cash/Personal Check (There is a NSF Fee of $30 for all returned checks)
* Care Credit
* Credit Card (Visa, MasterCard, Discover and American Express)
* **Insurance** Upon the ***INTIAL*** visit to this office, your Insurance Card ***must*** be provided.

PLEASE NOTE: As a Courtesy we will verify and file a claim to your **Primary** Insurance **ONLY**. You will be **given an Estimate of your out-of-pocket expenses prior to your surgery. (An** *ESTIMATE* is NOT a **guarantee of payment. If for any reason payment is less than estimate you will be billed and be responsible** to pay the balance. If payment is more than estimate you will **receive a refund.**)

All **Out-of-pocket Expense** is due **PRIOR** to treatment.

If you have a secondary insurance we will assist you in filing your own claim.

Monthly statements are sent to all patients with an account balance. A finance Charge of 1.5% is applied to all account balances over 90 days. Accounts are subject to being turned to collections if delinquent more than 90 days.

____
Signature of Responsible Party

RESPONSIBLE PARTY BILLING INFORMATION

Relationship to patient: o Self o Spouse o Parent o Legal Guardian o Other ____________

Name: ____________ Social Security Number: ____________ DOB: ____________

Address: ____________ City: ____________ State: ____________ Zip: ____________

Home Phone Number: ____________ Cellular Phone Number: ____________ Other: ____________

Employer: ____________ Business Phone Number: ____________

Insurance Information *MUST BE PROVIDED UPON INITIAL VISIT

Name of Insurance Company: ____________ Group Plan Number: ____________

Insurance Company Address: ____________ City: ____________ State: ____________ Zip: ____________

Insurance Company Phone Number: ____________ Fax Number: ____________

Policy Holder (Subscriber): ____________ Social Security Number: ____________ DOB: ____________

Policy Holder's Mailing Address: ____________ City: ____________ State: ____________ Zip: ____________

Policy Holder's Relationship to Patient: **o** Self **o** Spouse **o** Parent **o** Other ____________

I hereby authorize and direct ____________ Insurance Company to pay by check made out and mailed to:

Valley Oral & Maxillofacial Surgery
Attn: Insurance Department
4109 North 22nd Street
McAllen, Texas 78504

I understand the information I have provided on this form is essential. I understand that if any changes occur I will contact the office at once. I **authorize** the release of any information pertinent to my care to the insurance company. I **authorize** the doctor to initiate a complaint to the Insurance Commissioner if necessary. I have read and understand these questions and have answered them all truthfully and to the best of my ability.

_______________________________ ____________
(circle one) **Signature of:** Self Spouse Parent Legal Guardian Other **Date**