VALLEY ORAL & MAXILLOFACIAL SURGERY

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. As an added courtesy, we have made available to you the following payments options: **(PAYMENT IN FULL AT TIME OF SERVICES RENDERED)**

- Cash / Personal Checks
- Dental Fee Plan & Care Credit
- Credit Card (Visa, MasterCard, Discover)
- Insurance – Upon the **INITIAL** visit to this office, your insurance care (Medical and/or Dental) **MUST** be provided. This information will be given to the insurance department, your benefits will be verified and an **ESTIMATE** of out-of-pocket expenses will be provided to you prior to surgery. **THIS IS ONLY AN ESTIMATE AND NOT A GUARANTEE PAYMENT OF WHAT YOUR INSURANCE WILL PAY.**
  As a courtesy to you, we will file your insurance claim. If your insurance company underpays a claim, you will be responsible for the balance.

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. Please feel free to discuss any problems regarding your account with our insurance department.

_____ _____
Signature of Responsible Party Date

RESPONSIBLE PARTY BILLING INFORMATION

Please complete if someone other than the patient will be responsible for this account.

Relationship to Patient: □ **Self** □ **Spouse** □ **Parent** □ **Legal Guardian** □**Power of Attorney** □ **Other**

Name:_____ Social Security No: _____ D.O.B: _____

Address:_____ City:_____State:_____Zip Code: _____

Home Phone No: _____Cellular Phone No: _____ Other: _____

Employer:_____Business Phone: _____

INSURANCE INFORMATION

Name of Insurance Company:_____ Group Plan No: _____

Insurance Company Address: _____City: _____ State:_____Zip Code: _____

Insurance Company Phone Number: _____ Fax Number: _____

Policy Holder's Name (Subscriber): _____ Social Security No: _____ D.O.B: _____

Policy Holder's Mailing Address: _____City: _____State: _____Zip Code: _____

Policy Holder's Relationship to Patient: □ **Self** □ **Spouse** □ **Child** □ **Legal Guardian** □**Power of Attorney** □ **Other**

Patient's Student Status (if a dependent 18 years or older): □ **Full-Time** □ **Part-Time** □ **Does Not Apply**

School Name: _____ School Address: _____

I hereby instruct 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 authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand the information I provide on this form is essential to determine my treatment needs and the provision of treatment. I understand that if any change occurs, I will report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability.

_____ _____
Signature of : □ **Self** □ **Spouse** □ **Parent** □ **Legal Guardian** □ **Other** Date