# Drs. Oghalai, Krutoy and Toscano

## Patient Financial Responsibility

The providers and staff at Drs. Oghalai, Krutoy and Toscano appreciate the confidence you have shown in choosing us for your oral surgical needs. This financial policy is for your benefit in understanding our expectations with regards to payment, insurance and billing.

Payment is due at the time that services are rendered. If other financial arrangements are necessary, they must be made prior to treatment. Any partial paid balances are due and payable within 30 days from the date of services. Interest shall accrue on unpaid balances after the due date at the rate of sixteen percent (16%) per annum, until paid in full.

As a courtesy to you, we will file insurance claims directly with your insurance company, unless your plan requests otherwise. In order to do so, we MUST have accurate information regarding your insurance coverage. Payment of services rendered remains your responsibility, but we will gladly assist you in obtaining reimbursement from your insurance carrier. You are financially responsible for any and all services performed at Drs. Oghalai, Krutoy and Toscano. Please remember that we are non-participating providers with all insurances. An insurance contract is between the patient and the insurance company, NOT the provider. Our office does not accept the responsibility for collecting your insurance claim or negotiating a disputed claim.

You are expected to know and understand your insurance benefits and the insurance reimbursement policies from your carrier prior to your visit. This includes your oral surgical deductibles, co-insurance percentage and/or calendar year maximums as determined by your insurance. Not all services are covered with all insurance carriers. If your insurance carrier does not cover a service or procedure, you are liable for full payment of the bill.

Your estimated down payment is due and expected on the date of service.

You are responsible for providing proof of insurance coverage at each visit to our office and to notify us if your insurance has changed.

Once your insurance company has processed your claim(s), you will be billed or refunded accordingly. Payments are due upon receipt of your statement. Any account over 90 days past due may be turned over to collections.

Increasing delinquency in payment of accounts has made it necessary to obtain written consent to guarantee payment and/or financial responsibility of all accounts. In the event that it is necessary to refer your account to an attorney or collection agency for collection, the undersigned hereby agrees to pay, in addition to the balance due on the account, plus interest as set forth above, all of our costs of collection, including reasonable attorney's fees, collection agency fees, and expense of collection, including but not limited to court filing and service fees.

I hereby authorize Drs. Oghalai, Krutoy and Toscano to furnish information to my insurance company concerning my care. I further hereby assign all payments for services rendered to Drs. Oghalai and/or Dr. Krutoy and/or Dr. Toscano. I understand that I am financially responsible for all services rendered. I have read the above information and herby acknowledge receipt of a copy of the financial information and agree to the terms stated herein.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name (Printed) | Date | Patient/Guarantor Signature |

Staff Initials _____