Financial Acknowledgement and Agreement

We are pleased that you have selected our office for your oral surgery care. Our practice has grown as a result of the quality patient care we provide as well as our excellent relationship with our referring doctors and patients. We have developed this form so that you fully understand your financial responsibility for your oral surgery care.

Our ultimate goal is to provide the finest in oral surgery care for you or your family member. Our responsibility is to our patients and referring doctors. In order to preserve the finest doctor/patient relationship we are contracted with a limited number of insurance carriers. They are: Medicare, and Humana Choice Care (medical).

Our staff of business professionals will be happy to file an insurance claim for your oral surgery services to your *primary insurance carrier.* The benefit paid by your insurance carrier for these services may be less than the actual charge and is a direct result of the plan selected by your employer.

The care we provide is directly to our patient; therefore, the patient or their parent/guardian is fully responsible for all procedural fees in our office. Payment is due at the time service is rendered. Payment may be made by: cash, local check (with ID), money order, MasterCard, Visa, Discover, and American Express. Financing through Care Credit may be an option for patients who desire a monthly payment plan. This option is available to pre-qualified applicants (pre-qualified prior to their appointment date) for surgical fees in excess of $300.

I have fully read and understand the Financial Acknowledgement and Agreement. I understand and agree with my financial responsibilities for oral surgery care rendered by Gerald W. Bird, D.M.D., P.A. and Jay A. Johnson, D.M.D.

_____ _____

Patient Name

Patient/Legal Guardian Signature
(18 years of age or above only)

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Date