Oral Surgeons of Indiana ~ Payment Policy

Denise A. Flanagan DDS Mark W. Anderson DDS MS

Please read carefully and Sign

Welcome to our practice. Your health is our main concern and it is our policy to help you reach your optimum dental health. Additionally, we will attempt to make payment for your oral surgery services as convenient as possible. The following options are provided for convenience.

Payment is required as services are rendered

We accept Cash, Personal Checks, Care Credit and all Major Credit Cards.

Insurance:

A. If you have dental insurance, we will request a copy of your dental benefits insurance card. YOU are responsible for any balance not covered by your insurance policy at the time services are rendered.
B. For those patients who have a PPO insurance program ~ YOU are responsible for any co-payment set by your insurance company. This payment is due at the time the services are rendered.
C. If you have medical insurance, please let us know in advance. *Some* oral surgery services may be covered by your medical insurance plan.

Please indicate how you wish to pay your account

___ A. Payment as services is rendered ~ Cash, Personal Check, Care Credit, or Major Credit Card.

___ B. Insurance payment ~ balance will be paid by Cash, Personal Check, Care Credit or Major Credit Card.

I agree to pay for all professional fees and treatment at the time of service or the *estimated* co-payment not covered by insurance. I realize that I am also responsible for full payment of fees not paid by the insurance company within 30 days from the date of service. I also agree to pay interest at the rate of 1.5% monthly on any balances over 45 days from the date of service. I further agree to pay any collection agency fees, attorney fees, and court costs should these means of collection be necessary. I hereby authorize payment to Dr. Denise A. Flanagan and/or Dr. Mark W. Anderson of group insurance otherwise payable to me.

_____ _____

Signature of patient and/or responsible party Date

_____

PLEASE PRINT PATIENT AND/OR RESPONSIBLE PARTY NAME

Patient Disclosure Instructions

Oral Surgeons of Indiana
Denise A. Flanagan, DDS Mark W. Anderson, DDS, MS

Patient Name: _____

_____ OK to leave a message with detailed information on any phone numbers listed on your patient's profile paperwork.

_____ OK to mail to my home address.

I allow you to give my clinical information to or answer questions from:
(Check all that apply and name):

_____ Spouse/Partner_____
_____ Parent _____
_____ Child _____
_____ Other (Specify)_____

Patient Signature: _____ Date _____
Parent/Guardian Signature: _____ Date: _____

Acknowledgement of Receipt ~ HIPAA Notice of Privacy Practices
****You May Refuse to Sign****

I,_____, have seen this office's Notice of Privacy Practices.
(Please Print Your Name)

_____ _____ _____
(Your Signature) **(Patient's name if you are not the patient)** **(Date)**

_____