Oral Maxillofacial Surgery / Robert C. Urquhart, DDS

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Initial Exam Date: _____

Patient: (Mr., Mrs., Ms., Dr.) First Name_____ M.I._____ Last Name_____

❑ Single ❑ Married ❑ Divorced ❑ Separated Have you ever been a patient of our practice? ❑ Yes ❑ No

Nickname_____ ❑ Male ❑ Female Date of Birth ____ / ____ / ____ Social Security # _____

Address_____ City_____ State_____ Zip_____

Home Phone # (____) _____ Cell Phone # (____) _____

Employer_____ Tel. # (____) _____ Ext. _____

Dentist _____ Physician _____ Referred By_____

Driver's Lic # _____ Nearest relative not living with you _____ Tel. # (____)_____

Method of personal payment: ❑ Cash ❑ Check ❑ Credit Card

Email _____ Pharmacy/ Location _____

If responsible party is other than above or if the patient is a minor:

❑ **Parent** ❑ **Divorced Parent** ❑ **Legal Guardian** ❑ **Spouse** ❑ **Other**

Name _____ Date of Birth_____ Soc. Sec. # _____

Home Phone # (____) _____ Cell Phone # (____) _____

Street_____ City _____ State _____ Zip _____

Employer _____ Tel. # (____) _____ Ext. _____

Email _____

PRIMARY DENTAL INSURANCE

Do you have Medicaid? ❑ No ❑ Yes: Medicaid Program _____

Insured Party's Name _____ Relation to patient _____

Insurance holder's a address _____

Date of Birth _____ Sex: ❑ M ❑ F S.S. #_____

Employer_____ Bus. Tel. # _____

Insurance Co. Name _____ Group #_____

Insurance Co. Address _____ Phone _____

Do you have a secondary dental insurance carrier? ❑ No ❑ Yes: Carrier Name: _____

Subscriber ID # _____

PRIMARY MEDICAL INSURANCE

Insured Party's Name _____ Relation to patient _____

Insurance Holder's Address_____

Date of Birth _____ Sex: ❑ M ❑ F S.S. #_____

Employer_____ Bus. Tel. # _____

Insurance Co. Name _____ Group #_____

Insurance Co. Address _____ Phone _____

Subscriber ID # _____

Do you have Medicaid? ❑ No ❑ Yes: Medicaid Program _____

Do you have a secondary medical insurance? ❑ No ❑ Yes: Carrier Name: _____

Subscriber ID # _____

Oral Maxillofacial Surgery / Robert C. Urquhart, DDS / Financial Policy and Authorization

We are happy to file an insurance claim to your primary insurance carrier for you. Please understand that insurance companies rarely reimburse the full amount. usually paying between 50-80% of the cost under the maximum annual benefit after yearly deductibles have been met by the insured Also insurance companies do not routinely cover many oral surgery procedures. Therefore, **we collect a standard 30% of COVERED benefits for most insurance companies payable on the day of the surgery appointment. Non-covered benefits require payment in FULL prior to the surgical procedure.** If you do not provide us with complete and accurate insurance information you will be required to pay for all professional services in full at the time of service.

- If the insurance deductible has not been met during time of services, it will be added to the patients copay and due on the day of surgery.
- We will be happy to send a pre-determination request to your insurance company. We generally receive a reply in 4 - 6 weeks.
- If we are unable to send or receive a pre-determination due to time limits, we will provide an estimated copay based off your insurance benefits due on the day of surgery. Estimates are honored for 60 days and are subject to change.
- ***After*** the insurance has paid, you will receive a ***refund or a bill*** whichever is applicable. If you have a balance due after insurance has paid the balance is payable in full within thirty days of receipt of a statement.
- If your insurance company has not reimbursed us in full after forty-five days of filing your claim we will send a statement to the responsible party and the unpaid balance becomes due and payable within 30 days.
- General anesthesia / IV sedation is not usually covered for non-surgical tooth extractions.
- Insurance companies will usually only pay for one or two office exams per year. If you were examined by your general dentist and referred to this office, your exam fee at this office may not be covered
- Insurance companies will generally pay for a Panorex X-ray (full mouth/jaw x-ray) every two-five years. If the diagnostic quality of X-ray(s) provided by your general dentist are not acceptable we may require a new X-ray for today's exam visit and will not be covered by your insurance company.

➢ ***Payment in full is required for tooth extraction with local anesthetic when done the same day of the examination.***

➢ Financial arrangements are individualized for every patient for extraction of multiple teeth for the placement of dentures or partials. Insurance benefits are frequently used up for the year with the fabrication of the dentures. Atveoplasty (smoothing of bone for denture placement) is not a covered expense when performed concurrent with dental extractions.

➢ When a biopsy procedure is performed the specimen will be sent to a lab. You will be billed separately by the lab for their diagnostic services

➢ It is our policy to have **the insured file all secondary insurance claims**. Insurance Company policies regarding secondary insurance coverage is extremely varied and often times ambiguous. As a consequence, we are unable to effectively administer a program to file and resolve secondary insurance claims.

➢ ***We DO NOT accept out of state checks. Checks returned due to insufficient funds will be charged a $30 fee.***

➢ A service charge of 1.5% (18% APR) will be charged to outstanding accounts greater than 30 days.

➢ Outstanding accounts greater than 90 days will be turned over to a collection service.

➢ Patients wishing to finance treatment fees may be eligible for commercial financing through Care Credit Details, available on request.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount. Co-payment or any other balance not paid by your insurance company. The responsible party understands and agrees to the financial policy outlined above and will be responsible for all fees for treatment. The signature below is my authorization for release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____ **Witness:** _____

Signature of Patient (Parent or Guardian if minor)

Date: _____

We are required by the HIPPA (Health Insurance Privacy Portability Act) to maintain privacy of our patients. The notice of our legal duties and privacy practices with respect to protected health information is available for your review upon request. If you have any questions please ask to speak with our HIPPA Comphance Officer in person by phone at our Main Phone Number. Signature below is only acknowledgement that you have been informed of our Privacy Practices.

Signature: _____ **Date:** _____