

**Zieman, Pfeffle & Sheppard, DMD, PC**  
Practice Limited to Oral and Maxillofacial Surgery  
5901 Grelot Road, Mobile, AL 36609

To Our New Patients:

We welcome you to our practice of Oral and Maxillofacial Surgery and sincerely hope you will be satisfied with the relationship we establish.

Under normal circumstances the first appointment will consist of an oral examination, x-rays when necessary and a consultation with the doctor. If surgery is necessary, plans for either office or hospital procedures will be discussed.

- All emergencies and first visits are to be paid at the time of service. Thereafter, the business office has several financial arrangements available:
- Office Surgery- Without Insurance-full amount due day of surgery
- Office Surgery- With Insurance-one third of the surgical fee due the day of surgery with the balance paid within 60 days
- Hospital Surgery-Full payment on the day of admission
- Orthognathic Surgery (jaw surgery)-full amount not covered by insurance company the day of appointment prior to admission.

The surgical fee is the entire responsibility of the patient, parent or guardian. We accept payment by CASH, CHECK, VISA, MASTERCARD. We participate with the Care Credit Patient Financing Program. Please ask for details.

#### INSURANCE

Our office does not make financial agreements with any insurance companies or third parties. You will be responsible for payment of your balance when it is due. If insurance payments are made to our office after that date, you will be refunded or billed accordingly. If you are enrolled in a PMD or PPO plan and our office has a contractual agreement with that company you will be responsible for you co-payments and deductible.

Some insurance companies allow a predetermination of benefits prior to a procedure. If a written predetermination is obtained prior to surgery, you will be responsible for the amount not covered by your insurance company the day of your procedure. Payment due the day of surgery is determined by your primary insurance carrier only. If you would like a predetermination of benefits for your procedure, please discuss this with one of our insurance specialists.

The receptionist has full responsibility for collecting accounts, arranging financial plans and adjusting appointments. Please consult her about these matters to avoid delaying the doctors care of another patient.

You will be responsible for all returned check fees, collection fees, attorney fees, court cost and any additional fees that may be encountered to collect any outstanding balance. In the event that legal action is necessary, this corporation may seek a personal judgement against you. Please note that surgical appointments broken without 24 hours prior notice may result in a partial, non-refundable deposit prior to rescheduling. We will be happy to discuss any questions with you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Insurance Authorization

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Dental Insurance -Primary	Dental Insurance -Secondary
Insured's Name	Insured's Name
Insured's DOB	Insured's DOB
Relationship to patient	Relationship to patient
Employer	Employer
Name of Insur Co	Name of Insur Co
Insurance Address	Insurance Address
Telephone	Telephone
Group #	Group #
Policy #	Policy #
Social Security #	Social Security #

Medical Insurance- Primary	Medical Insurance-Secondary
Insured's Name	Insured's Name
Insured's DOB	Insured's DOB
Relationship to patient	Relationship to patient
Employer	Employer
Name of Insur Co	Name of Insur Co
Insurance Address	Insurance Address
Telephone	Telephone
Group #	Group #
Policy #	Policy #
Social Security #	Social Security #

### INSURANCE AUTHORIZATION

I the undersigned, as the patient or his/her authorized representative hereby authorize Zieman, Pfeffle & Sheppard, DMD, PC, to release to my insurance company(ies), that which is necessary to validate this claim.

\_\_\_\_\_  
Signature of patient or authorized representative

### ASSIGNMENT OF INSURANCE BENEFITS:

I do hereby authorize payment of all insurance benefits, basic and major medical to be made directly to Zieman, Pfeffle & Sheppard, DMD, PC.

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Signature of patient or authorized representative