Bay Area Oral Surgery

Practice Limited to Oral and Maxillofacial Surgery
5901 Grelot Road Building C • Mobile, AL 36609
9815 Millwood Circle • Spanish Fort, AL 36527

To Our 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 arangements available:
- Office Surgery - Without Insurance- full amount due day of surgery.
- Office Surgery with Insurance: PMD or PPO plans- you will be responsible for your co-payments and deductible. Traditional insurance and PMD or PPO plans that we are not contracted with: the full amount will be due the day of surgery and we will file for reimbursement as a courtesy. Please see section under insurance regarding predetermination of benefits.
- 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, AMEX, DISCOVER. 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 your 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 predeterminatlon 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. Failure to provide 24-hour notice for an appointment that you are unable to keep will result in a charge $50-$250 depending on the appointment type. Surgical appointments may require a partial, non-refundable deposit prior to scheduling. We will be happy to discuss any questions with you.

Signature: _____ Date: _____

Insurance Authorization

Patient Name_____ Date_____

Dental Insurance –Primary Insurance Card Holder:	**Dental Insurance –Secondary Insurance Card Holder:**
Cardholder's Name:	Cardholder's Name
Relationship to patient:	Relationship to patient
Cardholder's DOB:	Cardholder's DOB:
Employer:	Employer:
Ins Co Name:	Ins Co Name:
Ins Co Address:	Ins Address:
	:
Ins Telephone:	Ins Telephone:
Policy/ID:	Policy/ID:
Group #:	Group #
Cardholder SS #	Cardholder SS #

Medical Insurance- Primary Insurance Card Holder:	**Medical Insurance-Secondary Insurance Card Holder:**
Cardholder's Name	Cardholder's Name
Relationship to patient	Relationship to patient:
Cardholder's DOB:	Cardholder's DOB:
Employer:	Employer
Ins Co Name:	Ins Co Name:
Ins Co Address:	Ins Co Address:
Ins Telephone:	Ins Telephone:
Policy/ID#:	Policy/ID#
group #	group #
Cardholder SS #	Cardholder SS #

INSURANCE AUTHORIZATION

I the undersigned, as the patient or his/her authorized representative hereby authorize Bay Area Oral Surgery, to release to my insurance company(ies), that which is necessary to validate this claim.

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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 Bay Area Oral Surgery.

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Signature of patient or authorized representative