

FINANCIAL POLICY

Thank you for choosing UB Oral & Maxillofacial Surgery, Inc. as your health care provider. We are committed to building successful physician-patient relations with you and your family. Your clear understating of our Patient Financial Policy is important part of our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, or your responsibilities. To prevent any delays or difficulties, the office must be aware of any patient information changes (i.e) address, name, insurance information as soon as possible.

For your convenience, we accept Visa, MasterCard, Discover, CareCredit and checks with a valid NYS driver's license. (Out of town checks cannot be accepted.) If you have questions regarding your account, please contact our billing team at 716-899-4008. Many times, a simple telephone call will clear any misunderstandings.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

We understand situations arise. If it is necessary to cancel your scheduled appointment, we require that you call at least 24-hour notice in advance for appointments and 72-hour notice for procedures.

Am I responsible for payment if I don't show up for an appointment?

Cancellation and Missed Appointment Policy:

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

No Show/Cancellation Policy

A "no-show" is someone who misses an appointment without notice or does not cancel with the minimum required amount of time. A failure to present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed office appointment: **\$50 fee** will be billed to your account (*No future appointments will be made without arrangements to pay any outstanding balance on your account*).
- Second missed office appointment: **\$50 fee** and you may be discharged from our practice. Please be considerate of all our patients who are waiting for the next appointment.
- Surgical Procedure missed appointment: **\$150 fee** will be billed to your account.

Missed appointments may result in a dismissal from the practice.

Co-pays

Please present a current insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless arrangements have been made with our Billing Department. We accept cash, check, and credit cards. Absolutely no post-dated checks will be accepted. There will be an additional fee if the co-pay is not paid at time of service.

Insurance

Insurance is a contract between you and your insurance company. In most cases we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. To properly bill your insurance company, we require that you disclose all your insurance information including your primary and secondary insurance as well as any change of insurance information. Failure to complete all insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by the insurance, including but not limited to, those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to our office immediately.

High-Deductible Insurance Plans: If you have a high-deductible insurance plan you will be required to make payment at the time of your visit.

Self-pay

Self-pay accounts are patients without insurance coverage, or patients covered under insurance plans in which our office does not participate. Self-pay patients will be required to pay for services at the time of their visit and estimate of costs will be presented on the current retail rate.

Missed Appointments

UB Oral & Maxillofacial Surgery, Inc. requires 24-hour cancellation or reschedule notice prior to your scheduled appointment. Failure to provide adequate notice will result in a \$50.00 missed appointment fee. Repeated missed appointments may result in a dismissal from the practice.

Missed Procedures

UB Oral & Maxillofacial Surgery, Inc. mandates a 72-hour notice for cancellations or rescheduling of scheduled procedures. Failure to provide sufficient notification or absence without notification will incur missed appointment fee of \$150.00. Missed procedures without notification may result in a dismissal from the practice.

Completion of Medical Forms

There is a charge for the completion of medical forms (i.e., disability, FMLA, school forms etc.) Please consult with the office concerning fee, as it may change from time to time.

Minors

The parent(s) or guardian(s) is/are responsible for full payment and will receive the billing statements. A signed release to treat is required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent three statements. You may be contacted via mail regarding your outstanding balance. If payment is not made on this account, a phone call will be made to try to make payment arrangements. If no resolution can be made the account will be sent to the collection agency or attorney and possibly discharged from practice. Regardless of any personal arrangements that a patient might have made with our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service, office will not bill any other personal patient costs associated with our collection (including collection agency fees) will be passed on to you.

Consent/Authorization for Treatment Release Information/Disclose Personal Health Information

I hereby agree that UB Oral & Maxillofacial Surgery, Inc. may perform care and treatment, conduct such examinations, laboratories and procedures as are directed by my physician.

I hereby consent to use and disclose my Protected Health Information by UB Oral & Maxillofacial Surgery, Inc., for the purpose of treatment, payment, and health care operations. Example, my physician or treating physician at UB Oral & Maxillofacial Surgery, Inc. Any release of my medical records and Protected Health Information will be made according to the federal regulations. I understand that UB Oral & Maxillofacial Surgery, Inc. may release medical information to any third party which may be responsible for payment of my medical treatment.

I understand that I am financially responsible to UB Oral & Maxillofacial Surgery, Inc. for any bills not covered by insurance carrier.

I understand that by using credit cards for medical services I am forgoing state federal regulations regarding medical bills and understand that the use of credit cards for medical services is my choice that I am electing to use and is not a condition of treatment.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits to be paid to UB Oral & Maxillofacial Surgery, Inc.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY.

Name _____ Date _____