AVON ORAL & MAXILLOFACIAL SURGERY

6695 E. U.S. Hwy. 36, Avon, IN 46123
317-272-2200

Statement of Financial Responsibility

Thank you for choosing Avon Oral & Maxillofacial Surgery for your oral surgery needs. Your deposit required for today's surgery is $_____. Due to the constant changes in the insurance industry, it has become impossible for us to contact each insurance company to determine any guarantee of coverage for the services we provide. We will be happy to assist you in filing your insurance. Please remember that your contract is between you and your insurance company. If you have any questions regarding your deposit please notify the receptionist and a member of our team will be happy to speak with you.

PAYMENT OPTIONS AVAILABLE (please check one)

□DISCOVER	□CARE CREDIT
□CHECK	□AMERICAN EXPRESS
□VISA	□MASTERCARD

We also have a finance plan available through Care Credit. If this is an option you are interested in please ask our receptionist for an application or call our office for additional information.

Occasionally, due to factors beyond our control, some insurance companies may not reimburse Avon Oral & Maxillofacial Surgery within 60 days. If the payment has not been received from your insurance company within 60 days after treatment, Avon Oral & Maxillofacial surgery will require payment in full from the patient or responsible party. If payment is not received within 60 days after treatment, interest of 1.5% will be added monthly to your account's remaining balance.

****Should the account be turned over for collection, the undersigned agrees to pay any court costs, reasonable attorney fees, billing fees or collection fees as well as the remaining balance.**

****A service charge of $28 will be added for any check returned for NSF****

I have read and understand the financial policy of Avon Oral & Maxillofacial Surgery and agree to comply with all of the stipulations listed therein. I agree to financial responsibility for myself and others I am responsible for.

Print Patient Name _____Date_____

Print Guarantor Name_____
(Parent or guardian financially responsible for patient)

Guarantor Signature _____Date_____

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INSURANCE/NETWORK PARTICIPATION LIST

We participate and are in-network for the following groups:

DENTAL PLANS	MEDICAL PLANS
Aetna PPO	**Medicare**
Anthem Complete	
Anthem Dental Blue	
Careington	
Cigna PPO	
Delta Dental Plan	
Delta Premier Plan	
Delta USA Plan	
Health Resources, Inc	
H.I.P. (Healthy Indiana Plan)	
Medicaid	

Please be aware that many procedures that were previously considered dental procedures by insurance companies are now being paid under medical insurance (including but not limited to tooth extractions). Dental insurance companies are now forwarding or requesting we forward these claims to medical insurance before they will consider payment. Our doctors participate only with Medicare. If your claim is considered under your medical plan this may increase your out-of-pocket expense due to being paid out-of-network. We feel it is our duty to make you aware of this possibility due to the continuing changes in the medical and dental insurance industry. Many insurance companies are requiring written proof that the policy holders were informed of the possibility that these surgical services may not be covered. Therefore, please read and sign the following waiver required by insurance companies.

WAIVER

I have been notified by Avon Oral & Maxillofacial Surgery that the services provided might not be covered and/or paid under my medical or dental insurance policy. I am therefore responsible for any and all remaining balances charged by Avon Oral & Maxillofacial Surgery.

Print Patient Name _____ Date_____

Print Guarantor Name_____
(Parent or guardian financially responsible for patient)

Guarantor Signature_____ Date_____