



Oral Plastic Surgery Associates, P.A.

Dr. Don M. Preble

2009 Oral Plastic Surgery Associates Financial Policy

Thank you for choosing Oral Plastic Surgery Associates, P. A. as your dental care provider. We are committed to the highest quality of care at the most reasonable fee. Please understand that payment for your service is considered part of your treatment. All patients must complete our Registration and Health History form before having any treatment / consultation. The following is a statement of our Financial Policies which we require you to read and sign prior to any treatment. If an attorney is retained for any uncollected balance, all attorney and court costs will be your responsibility.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMEX,
AND CARE CREDIT**

Policy for No Show or Late Cancellation of a Scheduled Hygiene or General Dentistry Appointment

If you have a conflict in making your appointment call 48 hours in advance. If you NO SHOW or do not give the office 48 hours notice then your account will be charged a \$40.00 fee for missed appointment. This fee will be due before any further appointments are scheduled.

Policy for dental implant or surgical appointments

For these longer timed appointments a 10% non refundable deposit is required. There is a 72 hour advanced notice required to cancel an implant or surgical procedure. The 10% deposit will be forfeited if 72 hours advanced notice is not given to cancel the appointment.

After hours emergency visits

Any after hours emergency visits will be charged \$150 emergency fee plus the cost of treatment. Payments for these visits are due at the time of the visit with cash or credit card only.

Insurance Policy

We will no longer be accepting assignment of insurance benefits. We require payment in full at time of service and as a courtesy to our patients we will file your insurance. We cannot file your insurance unless you provide us with your insurance information. The insurance company requires us to file only for procedures we do on that specific date. Your insurance policy is a contract between you and your insurance company, we are not party to that contract.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the financial Policy. I understand and agree to this Financial Policy and accept that services rendered and payment is both part of treatment.

X _____
Signature of Patient or Responsible Party

Date _____