



## FINANCIAL AGREEMENT

To our patients,

Thank you for allowing us to participate in your health care.

In order that we may provide you with quality care we must request that payment be received at the time the services are rendered. As a convenience to you, we accept CASH, CHECK, VISA, and MASTERCARD.

In addition, we also participate with the following insurance carriers: Blue Cross Blue Shield of RI and MA, Delta Dental, United Health, Tufts, CIGNA, Altus Dental, AETNA PPO, MetLife, Healthcare Value Management (CCN), and the RI Medical Assistance Program. We will accept as payment the reimbursement allowed by each of these carriers WITH THE EXCEPTION OF ANY PAYMENT PROVISIONS THAT REQUIRE THE PATIENT TO BE RESPONSIBLE FOR THEIR DEDUCTIBLES, CO-PAYMENTS, AND NON-COVERED SERVICES. Because of the numerous plans that each carrier offers to its subscribers it is **impossible** for us to know all the contract requirements pertaining to deductibles, co-payments, and non-covered services.

It is important for our patients to be aware that other dental and medical plans made available to you vary considerably from one plan to the next. Few plans cover 100% of services, some cover nothing and most fall in the 50-80% range. Some plans also have deductibles and dollar limitations, and maximums per year. Please understand that our office will submit claims to your insurance company for reimbursement, but it is you whom is financially responsible for payments in full on all accounts.

Additionally, if your insurance plan requires a pre-determination or prior-authorization, we will submit a surgical treatment plan for review by your insurance carrier. However, please understand that the financial obligation for your treatment is between you and this office. Because patients often have dental work performed in other offices, it is **your** responsibility to keep track of insurance dollars paid in a calendar year. If there is any change to your insurance please notify us before treatment is performed.

### ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I authorize the release of any information relating to my insurance claim. I understand that I am ultimately responsible for ALL fees not reimbursed to East Bay Oral Surgery and Dr. Stephen N. Bakios.

Furthermore, I DO \_\_\_\_\_, I DO NOT \_\_\_\_\_ authorize payment directly to East Bay Oral Surgery, of the group insurance benefits otherwise payable to me.

This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges, whether or not they are paid by insurance. In the event any unpaid balance shall be referred to an attorney for collection, I understand that an attorney's fee equal to 33.33% of the total unpaid balance will be added to the balance due to help cover the additional costs of collection. I understand that there will be a charge of \$20.00 for any check returned.

\_\_\_\_\_  
Patient's or guardian's signature

\_\_\_\_\_  
Date