NORTH PITTSBURGH ORAL SURGERY

Oral & Maxillofacial Surgery

Finance Policy

Thank you for choosing North Pittsburgh Oral Surgery for your oral and maxillofacial needs. We value our relationship with you and would like share the following information regarding our Financial Policy:

For your convenience we accept cash, check, money orders, VISA, MasterCard, Discover, American Express, Care Credit, and Medical Bureau Loans as forms of payment. There is a returned check fee of $25.00.

Every effort is made to be as accurate as possible when estimates are provided. It is the final responsibility of the patient or insurance policy holder to have particular and detailed knowledge of your own individual policy parameters as your insurance policy is a contract between you and your insurance company.

A predetermination of benefits can be sent at your request to your insurance company. Treatment will be delayed until the processing of the predetermination is complete which can take up to several weeks. This predetermination is merely a guide for what future payment could be and does not guarantee final payment.

The final fee total will depend upon specific services provided and a determination from your insurance, and may be more or less than what was estimated.

Coverage for a performed service is never guaranteed. When submitting to a participating insurance provider the terms of your insurance plan preside over all other materials that may have been provided. The final decision is made by the insurance company upon the receipt of the claim.

Any non-covered procedures, co-pays, deductibles, fees, etc. that are determined to be your responsibility are due the date of the procedure.

Please be aware that there are certain procedures that may be quoted as covered, or partially covered, which result in a denial from the insurance company. There are many detailed policy guidelines for each patient's individual insurance policy and not all of those are provided to the NPOS billing department at the time when benefits are verified. Insurance companies reserve the right to review the services that are provided in order to determine if they are medically necessary.

Full financial responsibility falls to the patient once all avenues of insurance have been exhausted for any non-covered procedures, co-pays, deductibles, fees, etc. regardless of whether or not the procedures were originally included in an estimate that was given.

The signature below acts as authorization for the release of information necessary to process your dental and medical claims as well as authorization of payments to NPOS of benefits otherwise payable to you.

Signature of Patient (Parent/Guardian if Minor): _____ Date:_____