FINANCIAL POLICY

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE

Please indicate your method of payment:

Cash___ Check___ Master Card, Visa or Discover___ Care Credit Financial Application___

Insurance Policy

If you have Medical and/or Dental Insurance it is our policy to accept assignment on what we ESTIMATE will be your portion. Your estimated portion, which we have determined to be *40%* of our total fee, is due in full at the time of service. For further orthognathic surgery, *20%* is due in full on/or before surgery. All contractual co-payments are also expected at the time service is rendered. In order to do this, we must have a current, completed, signed insurance form, updated annually, and a copy of your insurance card. Any insurance benefits you have are an independent contract between you and your insurance provider. We are not a party to that contract. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates, payments or denials. In addition, you are responsible for keeping us informed of your insurance status so that we may obtain your insurance benefits in a timely fashion.

Payment Plans/Service Charges

All other payment options, such as payment plans, must be approved by management and is subject to a 1.5% service charge on all balances over 90 days.

Your signature below verifies that you have read and understand our policies and procedures prior to any services performed, and that you understand and consent to the terms of our financial policy and your financial responsibility.

I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS FOR REIMBURSMENT AND PAYMENT OF CLAIMS FROM MY INSURANCE PROVIDER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE PROVIDER. IF FOR ANY REASON THE ACCOUNT SHOULD BECOME DELIQUENT, I AGREE TO PAY FOR ALL COLLECTION FEES (INCLUDING AN ADDITIONAL $25.00 DELIQUENCY FEE), ATTORNEY FEES, COURT COSTS AND ANY ADDITIONAL LEGAL FEES. IF TREATMENT IS FOR A CHILD OF DIVORCED PARENTS, THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL PAYMENTS. WE CANNOT BILL THE OTHER PARENT.

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Signature Date

I hereby authorize said assignee to release all information necessary to secure payment. I hereby assign my insurance benefits to be payable to the office of Dr. Frederick L. Steinbeck, DDS MD. This assignment will remain in effect until revoked by me in writing.

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Signature Date