

**CAROLINA ORAL & FACIAL SURGERY, P.A.**  
**FINANCIAL POLICY**

Thank you for choosing Carolina Oral & Facial Surgery for your oral surgery needs. Our office is committed to providing you with the best possible care. You are the single most important person making decisions regarding your health. After consulting with us, you decide if treatment is right for you. We have developed the following policy to assist you in understanding and managing your fiscal responsibility.

**If services rendered total \$300.00 or less, the patient is responsible for payment in full. If charges exceed \$300.00, 50% and any unmet deductible and co-insurance must be paid at the time services are rendered. The following exceptions apply:**

- **The Greenville, South Carolina office is contracted with the following private insurance plans: Prisma Promise Health Plan (medical), Delta Dental Premier, and Blue Cross Blue Shield of SC and BCBS national grid plans.**
- **The Greenville, South Carolina office participates with South Carolina Medicaid.**
- **In the event, a patient *does not have Insurance*; PAYMENT IN FULL is expected at the time of service.**

An estimate of the charge for any procedure a patient requires will be provided to you upon request. If a patient has any dental and/or medical insurance we will be happy, as a courtesy to our patients, to submit your insurance claims, x-rays and any other necessary information related to treatment. Patients are responsible for submitting the correct insurance information to our office. However, since our professional services are rendered to you and *not* to the insurance provider, you are solely responsible to us for your financial obligations. After the insurance company has made payment on your account, any refunds will be issued to you after receipt of payment.

Once the insurance payment has been received, if a patient's account is not paid within 45 days, the account will be placed with a collection agency. Accounts are subject to a \$5.00 monthly service charge. In the event an account is turned over to a collection agency or attorney, the patient or person responsible for the patient's account agrees to pay a collection, court costs and any other reasonable costs of collection. For billing and payment inquiries, please contact our business office on 864-458-9800.

**Insured Adult Children:** I am responsible for informing my parent(s) of the proposed surgery and financial arrangements.

**If I miss a scheduled surgery appointment, and do not provide 24 hours notice to COFS, I understand I may be billed and responsible for a \$75.00 missed appointment fee.**

To determine liability for payment and to obtain reimbursement, I, the party responsible, authorize disclosure or portions of the patient's record. I hereby assign all medical and / or surgical benefits, to include major medical / dental benefits to which I am entitled, including PRIVATE INSURANCE, WORKERS' COMPENSATION, and other health plans to Carolina Oral & Facial Surgery, P.A. This assignment applies to all charges outstanding as of the date of this signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am responsible for all charges. **Contractual write off will only be applied if you have South Carolina Medicaid, Delta Dental Premier, Blue Cross Blue Shield of SC and national grid BCBS plans, and PRISMA Promise Health Plan (medical).** Carolina Oral & Facial Surgery, P.A. accepts cash, personal checks, VISA, MASTERCARD, and Care Credit. **All credit card transactions over \$4000.00 will incur a 3% surcharge.** Care Credit is an outside financing option available for our patients. They offer a convenient six-month, no interest payment plan in which our office participates. The application process is easy and may be completed online at <https://www.carecredit.com> Please let our business office know if you are interested in this financing option.

**I hereby authorize that this signature on file is my authorization to release all information necessary to process my claim and secure payment.**

**I have read and understand the financial policy of Carolina Oral & Facial Surgery for \_\_\_\_\_**  
**Patient Name**

**Signature of Patient / \_\_\_\_\_**  
**Legal Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_**