D. ERIC REDMON, D.D.S.

ORAL & MAXILLOFACIAL SURGERY

Diplomate, American Board of Oral & Maxillofacial Surgery

Fellow
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FINANCIAL CONSIDERATIONS

Dear Patient,

Payment is due at the time of your visit. We are happy to file your primary insurance one time as a courtesy. This office participates with certain insurance companies. We will try to give you the most accurate information as to your portion of the balance. Please remember this will be an estimate only. This is not a guarantee of payment from your insurance company. This is also not a guarantee that we have been given the correct information from your insurance company. We strongly recommend that you contact your insurance company directly for an explanation of your coverage. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I authorize Dr. Redmon to release all information necessary for payment or to settle dispute. I authorize direct payment to Dr. D. Eric Redmon. I also authorize release of my medical records as necessary for continuing medical care and payment.

A definite payment schedule **must** be pre-arranged with the financial coordinator before the surgery. For our patients who do not have insurance, one-half of the estimated payment is due at the time of surgery. Any fee mentioned preoperatively is only an estimate, and may vary depending on the actual surgical difficulty. This office reserves the right to not offer credit to any person.

Notice to Medicare patients!! Dr. Redmon does not participate with Medicare and is not a Medicare provider. Your signature on this form is indication to Dr. Redmon, his office and to Medicare that you have been notified according to Medicare and Federal regulations. This office does not participate with Medicaid.

Monthly statements will be mailed to our patients with a balance, interest charges will be assigned automatically on accounts over 60 days old. Most insurance companies take longer than 60 days to send a check. Patient/Guarantor agrees to immediately forward any insurance payment received by them, endorsed to Dr. Redmon, if an outstanding balance remains on their account. Payment is due upon receipt of the statement, and no later than the 20th day of the billing month. A re-billing charge of $5.00 may be added to the account if no payment is received for the previous month. Please understand that the account is the responsibility of the patient, guardian, or accompanying parent. Any legal fees required for Collection of the account will be added to the balance at 33 1/3%.

I have read the above information. By way of original or copy hereof, the undersigned patient/responsible party hereby agrees to the financial policies of Dr. D. Eric Redmon. I understand that identification is required and will be copied and kept in my file.

WE WILL **NOT** INITIATE CARE IF THIS FORM IS NOT COMPLETED IN FULL AND SIGNED.

Name of Patient:_____ Date:_____

Signature of Patient or Responsible Party: _____

Relationship to Patient:_____