

RONEN GOLD, D.D.S.
BOARD CERTIFIED, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
ORAL AND MAXILLOFACIAL SURGERY OF WESTFIELD

PATIENT RESPONSIBILITY AGREEMENT

Patients are required to pay for services when they are performed. Cash, Visa, MasterCard, and/or patient financing are all acceptable forms of payment.

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payment of the account, and **responsible to resolve any problems with your insurer.**

We will be happy to request a pre-estimate of benefits from your insurance carrier, if you request us to do so. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double coverage (this is possible if you and your spouse both have insurance), there may still be a portion that will be your responsibility. In order to maximize your insurance coverage, we will submit your claim to your medical insurance. In certain instances, your medical insurance company will send the insurance check directly to you. In order to properly coordinate all of your insurance benefits, you agree to forward all payments and explanation of benefits directly to Dr. Gold's office. If the insurer has not paid the benefits to our office within 45 days after submission, our office may then require payment for the patient services in full and any insurance benefits later received by our office will be returned to you.

If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our office manager will assist you in arranging a payment schedule.

Please check one: I have paid my insurance deductible for the current year Yes No Don't Know

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Ronen Gold. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor /Patient's Signature _____ **Date** _____

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.

ADDITIONAL TERMS

Surgery appointments cancelled with less than 24 hours notice may be subject to a \$300.00 cancellation charge. The practice reserves the right to dismiss patients with excessive cancelled appointments. Accounts greater than 30 days past due will be subject to a finance charge at the rate of 1.50% per month. If your account is referred for collection, you will be responsible for: collection costs up to 35% of the outstanding balance, court costs and reasonable attorney's fees. Returned check fee: \$75.00

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE.

X _____ DATE _____

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best possible care.