WELCOME

Drs. Gruskin, Lucas, Ferrara, and Staff are pleased to welcome you to our practice. We look forward to providing you with the most modern oral surgery care available.

IMPORTANT — Please read the following.

FINANCIAL ARRANGEMENTS (Self-pay and Insurance patients)

Prices quoted over the phone are only an estimate. Exact quotes of services will not be given until the patient has been seen by the doctor. We require payment in full at the time of service of anything not covered by an insurance company.

Service Charges of one and a half percent (1.5%) per month or eighteen percent (18%) annually will be added to your account after sixty (60) days to any unpaid balance. This amount will be your responsibility.

We accept Cash, Checks **(BUT NO COUNTER CHECKS, PLEASE)**, VISA, and MasterCard and Care Credit. We reserve the right to contact your bank before any procedures to make sure that you have the monies available to cover your check. There will be $30.00 charge for any returned checks. We do not accept post dated checks.

INSURANCE INSTRUCTIONS (Insurance patients only)

We file your insurance claims as a courtesy to you. Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and the insurance company, and payment for the services is your responsibility. We do not determine the amount of coverage you will receive. This is done by your insurance company. Any questions you may have concerning your insurance benefits should be directed to your insurance representatives. We reserve the right to refuse accepting the assignment of benefits for some insurances. We will be happy to submit your claim for you.

At the time of service, we will call your insurance company and get an "estimated payment" for the services rendered. The "estimated" portion that the insurance company does not pay is requested at the time of service, in full. After your insurance pays, you will be billed for the amount that differs from the estimate that was made at the time of the service. Should the insurance pay more than anticipated, we will issue a refund check to you. **If we are accepting assignment from your insurance company, you will need to sign the following two (2) statements**:

I HAVE BEEN INFORMED OF THE TREATMENT PLAN AND ASSOCIATED FEES. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR SERVICES AND MATERIALS NOT PAID BY MY INSURANCE, UNLESS THE TREATING SURGEON HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Insurance - This line must be signed: X_____
Signed (Patient OR Parent/Guardian if Minor)

I HEREBY AUTHORIZE PAYMENT OF BENEFITS. OTHERWISE PAYABLE TO ME, DIRECTLY TO DRS. GRUSKIN, LUCAS, AND FERRARA, P.C.

Insurance - This line must be signed: X_____
Signed (Insured Person)

I HAVE READ AND UNDERSTAND THE STATEMENTS OUTLINED ABOVE IN THE FINANCIAL ARRANGEMENT AND/OR INSURANCE INSTRUCTION SECTIONS.

Self pay and Insurance – This line must be signed:

X_____ _____ _____
Signed (Patient OR Parent Guardian if Minor) Relationship to Patient Date

Please read and sign front and back pages