Morris Sussex Oral Surgery Associates, LLC

Kurt Notarnicola, DDS
Board Certified Oral and Maxillofacial Surgeon
Tel: 973-601-0606 Fax: 973-601-1444 www.drkurtnj.com

FINANCIAL AGREEMENT

Please read the following and sign in the appropriate locations. If you have any questions, please ask.

1. I _____, the undersigned, assign directly to Morris Sussex Oral Surgery Associates, all insurance benefits, if any, otherwise payable to me for services rendered. **I understand I am financially responsible for all charges, whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits, manual or electronic. Deductibles or co-payments, if applicable, must be made at the time of service.

   Signature: _____ Date: _____

   Name (printed):_____

2. **Financial Agreement:** I acknowledge that payment is due at the time of treatment unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. **I accept full financial responsibility for all charges not covered by insurance plans. Estimated fees for service will be provided after examination. Estimates are not guarantees of payment by your insurance company. Your insurance company may pay less than estimated in which case you are responsible for the balance.** All legal/collections costs incurred will be the patient's/guardian's responsibility. These costs will be added to the outstanding balance. If any overpayments are made, a refund will be issued to the patient/guardian**. Please note there will be a charge of $50 for cancellations made within 24 hours of your appointment.**

   Signature: _____ Date: _____

   Name (printed): _____

3. **Minor/Child Consent:** I, _____ (parent/guardian), being the responsible party for _____ (child's name), acknowledge that I am responsible for payment of all fees incurred for treatment. Financial arrangements made between parents are not the responsibility of Morris Sussex Oral Surgery Associates.

   Signature: _____ Date: _____

   Name (printed): _____

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Insurance Memo

We participate with the following insurances only:

DENTAL: Ameritas PPO, Cigna PPO (not direct advantage), Delta Dental, Fidelio – Local 825 Operating Engineers, Guardian Dental Guard, MetLife

We are a surgical practice and our billing and claims submission requirements are different than those for a regular dentist. We are required to submit some claims to your medical insurance and your dental insurance. This is a common requirement for procedures including removal of wisdom teeth, biopsies, bone grafts and others. In many cases we are required to first submit the claim to your medical insurance company before we can submit it to your dental insurance. We will give you our best estimate but your dental insurance may pay a different amount than anticipated based on your medical insurance carrier's payment or deductible. Most medical carriers will not give us this information so we can only give you our best estimate based on the information available to us. Medical insurance carriers will send you an explanation of benefits (EOB) which we need to submit your dental claim. Medical insurance companies will not send the EOB to us, they will send it directly to the patient or policy holder. We ask that you please provide us with the EOB as soon as you receive it so that we can submit your dental claims. If we are not given a copy of the EOB we will not be able to submit the claim to your dental insurance carrier and you will be responsible for the entire balance based on our regular fees. We are sorry for any inconvenience this may cause but it is out of our control. These are standard rules that all dental insurance carriers make us follow.

I acknowledge that Morris Sussex Oral Surgery may be required to submit my claim to my medical insurance carrier. This may change the amount that my dental insurance company pays. If I receive an EOB from my medical carrier, I will forward it immediately to Morris Sussex Oral Surgery so the remainder of the claim may be processed by my dental insurance.

Name: _____ Date:_____

Signature:_____

Relation to patient: _____