



ORAL AND MAXILLOFACIAL SURGERY  
16511 goldenwest st. #109 huntington beach ca 92647

## Financial Agreement

Welcome to our office. As our health care system has changed, there has been some confusion regarding financial responsibility of the patient for medical treatment. This form is intended to clarify your responsibilities.

We value our patients and are committed to providing the highest quality services from a Board Certified Surgeon.

Thank you for choosing our office for your surgery care.

1. I understand that payment for the medical services is due the day the services are rendered. Payment for cosmetic surgery is due two (2) weeks prior to the date of the procedure.
2. I understand that outstanding balances must be paid prior to being seen by one of the surgeons.
3. I understand and agree that I am responsible for payment of all charges on my account. If my insurance company fails to pay within 60 days, or denies the claim for any reason, I will be responsible for the full amount due.
4. I understand and agree that my insurance carrier's deductible/co-payment/co-insurance/etc. is to be paid by me on the day services are rendered.
5. I understand and agree that after my insurance carrier processes my claim(s), there could be a balance still remaining to be paid by me and I will pay this balance immediately upon receipt of my patient statement.
6. I understand and agree that if my account is placed into collection action, I will be responsible for all the costs of such action. I will be responsible for all the costs of such action, (collection agency and attorney's fees included).
7. I understand that a photocopy of my Driver's License and/or my Insurance card will be required on the day of my visit.
8. I hereby authorize payments directly to Simona C. Arcan, DMD, MD. Inc. for insurance benefits otherwise payable to me.

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Patient's (or Legal Guardian's) Signature

Date

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Financial Coordinator Signature

Date



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## Financial Policy

OUR GOAL is to create an optimal experience from beginning to end. We believe open communication is essential to secure that our relationship is managed professionally and thoroughly. We understand oral surgery services are often unplanned and therefore, can create a strain on your family budget. We hope providing several account options will help you make arrangements to schedule treatment without delay.

- Payment for treatment is due the day the services are rendered unless other arrangements have been agreed upon.
- Patients are responsible for payment of all charges on their account. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.
- Insurance carrier's deductible/co-payment/co-insurance/etc. is to be paid on the day services are rendered.
- Any balances still remaining on your account after 60 days regardless of any pending claims will be cleared by the patient. We are committed to submitting claims (electronically for most insurance carriers) within 24 hours of your treatment.
- A copy of the patient's insurance card may be requested on the date of consultation.
- If a patient's account is placed into collection action, the patient is responsible for all the costs associated with such action (collection agency and attorney's fees included).
- In respect of your time appointments are CONFIRMED WHEN THEY ARE MADE. We kindly request a minimum two day notice if your personal schedule requires you to RESCHEDULE. Advance notice allows us to contact someone waiting for care.
- You, the patient, authorize payments directly to Simona C. Arcan, DMD, MD. Inc. for insurance benefits otherwise payable to you.

The accepted forms of payment are cash, check, Visa, MasterCard and CareCredit.