



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.

Patient's (or Legal Guardian's) Signature

Date

Financial Coordinator Signature

Date