iCare Oral Surgery
Dental Implant Center

William L. Thompson DDS, MD
Fellow of the American Board of Oral and Maxillofacial Surgery

OFFICE BILLING POLICY

(This form requires review and signature)

Insurance copays will be collected on the date of service. If you do not have insurance the balance is due IN FULL on the date of service. If you are not able to pay your copay or balance at this time, please reschedule your appointment. For your convenience, our office accepts Care Credit, Visa, MasterCard, Discover, American Express, personal checks, and Cash.

There is a $35.00 returned check fee

We require 24 hours' notice for cancelled and/or rescheduled appointments. If this policy is not followed there may be a cancellation or no show fee.

Our office works hard to check eligibility and benefits for our patients. However, due to the many changes and complexity of the insurance companies, it is no longer an easy task to interpret each individual policy 100%. As a courtesy, we will provide an ESTIMATE of your copay and coverage for your treatment needs. However, this is only an estimate and not a guarantee of payment from your insurance company. **It is your responsibility to understand your benefits, special terms, deductibles, and copays of your insurance policy.**

If after 90 days, we have not received payment from your insurance company, our office reserves the right to transfer the entire balance to the patient for payment. It will then be the patient's responsibility to contact the insurance company with questions, concerns, and/or reimbursement.

Please remember that your insurance policy is a contract between you and your insurance company, Not with the company and your healthcare provider.

The intention of this notice is to clarify our office policies and procedures and to promote good patient-provider communication.

I understand the billing procedures associated with this office and that additional charges may be incurred if I fail to comply. I agree to pay ANY and ALL balances set forth by my insurance company and/or charges set forth by this office.

_____ _____

Print patient name Date

_____ _____

Signature of patient (Guardian if under 18 yrs old) Relationship to patient