Valley Oral & Maxillofacial Surgery, P.A.
Vito L. Modugno, DMD

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to making your treatment as comfortable and successful as we can provide. Please understand that payment for service rendered is considered a part of your treatment. The following is our Financial Policy, which we require you read and sign prior to any treatment.

Patients without Insurance Coverage

Full payment is due at the time of service; unless a prior arrangement has been made.

Patients With or Without Insurance Coverage Who Desire Payment Plan Options

We can provide you with a three, six or nine month interest free payment plan, only if you pre-qualify. The payment plan is through **CARECREDIT.** If interested, our staff will be more than willing to assist you.

Patients where we are a Participating Provider

Co-payments, Deductible, and/or Coinsurance are due on the day of treatment. Our staff will make every effort to provide you with information on predetermination of benefits and estimated expenses for treatment. In situation where you have reached your maximum allowable coverage, it will be your responsibility for all payments above and beyond your policy limits. The information we gather from your insurance company is never a guarantee of coverage and/or payment. **Your insurance policy is a contract between you and your insurance company**. In the event your insurance coverage changes, it is your responsibility to inform us.

Patients Where We are Not a Participating Provider

On a case by case basis, we will accept assignment of insurance benefits paid directly to our office if your policy provides for this provision. Payment of all deductibles and coinsurance are due at time of service.

Usual and Customary rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Once our office receives the insurance payment, you will be billed for any remaining balances not covered by your insurance. Any remaining balances are your responsibility whether your insurance company pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical or dental insurance. You will have thirty (30) days to pay your remaining balance. Your prompt remittance is appreciated. Please call our office if your statement does not reflect your insurance payment within that time frame at 973-636-9660. Many times, a simple telephone call will clear any misunderstandings.

For your convenience, we accept **Visa, MasterCard, American Express and Discover**.

Balances exceeding 60 days past due will incur a 1.5% monthly interest rate. If your remaining balance is delinquent after 90 days, your account will be turned over to a recovery agency. Your account will then incur an additional 35% fee to cover collections costs. Should our office find it necessary to retain the services of an Attorney you will then be responsible for all incurred legal cost.

I hereby authorize Dr. Vito L. Modugno/Valley Oral & Maxillofacial Surgery, P.A. to release to my insurance company, information acquired in the course of my care. I hereby authorize benefits to be paid directly to this office.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy.

All patients *must complete* the entire Information Form before seeing the Doctor. NO EXCEPTIONS
(The adult accompanying a minor and the parents (guardians of the minor) are responsible for full payment).

_____ _____
Signature of Patient or Responsible Party Date

_____ _____ _____
Driver's License Number Expiration Date State