Jeffrey M. Eisner, D.M.D., P.A.

Financial Agreement

Patient Name: _____

Welcome to our office. As our health care system has changed, there has been some confusion regarding financial responsibility of the patient for medical/dental treatment. This form is intended to clarify your responsibilities as our financial policy is based on an open and honest discussion of fees.

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.

- ***INSURANCE:*** **We will bill your insurance company for your visits as a courtesy to you. Due to the difficulty of obtaining payment from your insurance plan, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify their benefits and/or limitations prior to their visit(s) and those we are a participating provider of your insurance plan. If we are not providers, or out of network or a benefit is not covered, you will be responsible for any and/or all of the balance for the services rendered.**

- **Please be advised that Dr. Eisner's specialty falls under both Dental and Medical therefore, we need you to provide us with both of your insurance policies.** ***Example:*** **If you are here for any treatment involving your lip, gums, tongue, jaw, infection or an abscess in your mouth (soft tissue or bone) we will require your medical information. If you are here for an extraction or surgical exposure we will need your dental insurance information. If you are here for an implant please be advised that you will be responsible for the cost of all treatment(s) rendered.**

- **I understand that payment for services is due the day the services are rendered. When scheduling surgeries we do require a 50% deposit to hold your surgical time. Surgeries need to be cancelled within a minimum of 48 hours notice to avoid a $200 cancellation fee. Please note that with some insurance carriers mainly HMO policies, surgeries need to be pre-authorized where as with PPO and Indemnity policies, pre-authorization is recommended. As a courtesy to our patients we will submit all necessary paperwork and X-rays to your carrier for this process to be accomplished. Dental pre-authorizations usually require 6-8 weeks and for medical procedures 1-2 weeks. If for some reason you do not wish to pre-authorize, you would be responsible for paying the surgery in full and we would submit the claim for you so you can be reimbursed directly from your carrier.**

- ***HMO/REFERRALS:*** **It is your responsibility to obtain a referral from your primary care physician and/or dentist if your insurance carrier requires one for your visit. A referral from an orthodontist is not valid for your insurance. It is the patient's responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and were required to bring one, your appointment will be rescheduled.**

- **I understand that outstanding balances must be paid prior to being seen by Dr. Jeffrey M. Eisner.**

- ***LABORATORY FEES:*** **If pathological services are performed in our office, the use of an outside laboratory will be necessary. The pathological review and report will be billed to you separately from the laboratory. If is your responsibility to inform us if your insurance carrier/plan utilizes a specific outside laboratory. The average fee for oral specimens' pathological review by an outside laboratory is $100-$200. If an orthotic appliance is necessary, our office will collect the laboratory fee from you. If your insurance pays for this you will be reimbursed.**

- ***SERVICE CHARGES:*** **The policy of this office is to charge a $20 rebilling fee on all accounts that are over 60 days past due. Our first bill will be complimentary.**

- **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. After the 60 day period the full amount due will begin to accrue interest at the highest rate permitted by the Florida Law.**

- **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.**

- **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 or interest will start accruing immediately.**

- **I understand and agree that if my account is placed into collections, I will be responsible for all the costs of such action. Including but not limited to a collection agency and/or attorney's fees.**

- **I understand that a photocopy of my Driver's License and my Insurance cards will be required on the day of my visit.**

- **The fact your insurance carrier may not cover a service does not mean that you should not received the service. There is a medical / dental reason for why your Doctor recommended said service(s). The purpose of this form is to help you make an informed choice about whether or not, to receive said service(s) understanding that you may have to pay for this yourself. Please read this information in its entirety prior to signing.**

- **It is the patient's responsibility to obtain verification of their insurance plan benefits. Verbal or Online verification is NOT a guarantee of payment. Services are subject to the limitations and exclusions including pre-existing conditions as stated in the insurance benefit plan.**

By signing below, I have read, fully understand and accept the financial agreement. I hereby agree to render payment in accordance with the terms and conditions set forth. Jeffrey M. Eisner, D.M.D.,P.A., has the right to refuse providing service if the terms of this contract are not accepted.

Patient/
Responsible Party Signature: _____

Print Patient Name: _____ **Date:** _____