NORTHERN MICHIGAN ORAL AND MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

FINANCIAL POLICY

An explanation of fees before surgery is helpful to all concerned. We will provide you with an estimate for your treatment. ***Please remember, it is only an estimate.***

If you have NO dental or medical insurance: You are responsible for full payment on the date of service for the treatment rendered.

If you have dental insurance: We will bill your services to your insurance as a courtesy to you. Every insurance carrier is different, and it is recommended that you check with your carrier to determine your level of coverage before undergoing surgery. Any benefits paid by your dental insurance, should be paid to the subscriber. However, the payment may not be the same as our fees. If you wish to have a predetermination of benefits obtained from your insurance carrier, please ask. We will submit a predetermination to your insurance carrier on your behalf.

If you are a **Delta Dental of Michigan** (Premiere or PPO Program) subscriber, you are responsible for any non-covered services, deductible, or co-payment on the date of service. If you wish to have a predetermination of benefits obtained from your insurance carrier, please ask. We will submit a predetermination to your insurance carrier on your behalf.

If you have medical insurance: It may be required that we bill them before your dental plan will consider the claim for benefits. Please present both your dental and medical insurance information (cards) at the time of your appointment. Some medical insurances require a referral and/or an authorization from your primary care physician. You are responsible for contacting your primary care physician (PCP) office and obtaining the paperwork needed for each visit. Failure to provide all the insurance information or obtain this authorization may require postponement of your visit and/or result in non-payment, or reduction in the payment, for your procedure.

AUTHORIZATION AND CONSENT

Authorization to bill dental and/or medical insurance: I hereby authorize Northern Michigan Oral and Maxillofacial Surgery, P.C. to furnish information to my insurance company concerning my care.

_____ _____
Date Signature of Patient/Parent/Guardian

Consent to pay for services rendered: ***I understand that I am responsible for full payment on the date treatment is rendered.***

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Date Signature of Patient/Parent/Guardian