HOW MUCH WILL MY INSURANCE PAY

As we have discussed, we will submit your insurance claim if contracted to your Primary insurance. However, health insurance is a contract between an individual and your Insurance Company. You are ultimately responsible for the treatment costs whether the insurance company pays or not. Very few insurance plans pay 100% of the costs.

Insurance companies pay health costs according to fee schedules which they have devised. These fee schedules may or may not call their fees "USUAL, CUSTOMARY, AND REASONABLE". In fact, they are often based on information gathered one to three years ago and may include surgical fees of non-specialized practioners. Therefore, in most cases what a physician charges will be higher than what the insurance company pays. This does not mean that the physician is overcharging; it means that the INSURANCE PAYS WHAT IT HAS AGREED TO PAY, not what is charged.

We will be glad to help you with your insurance forms and assist you in getting payment from your insurance . However , if payment of a claim is delayed for more than sixty (60) days for any reasons, ie: must be submitted to medical carrier (we are not contracted)for any reason, the balance becomes due and payable in full and becomes subject to finance charges of 18% Apr. In addition, any insurance payment and patient co-payment amounts we give ARE ESTIMATES ONLY, NOT A GUARANTEE OF PAYMENT OR RELEASE OF FURTHER RESPONSIBILITY, and are subject to your individual plan's provisions and limitations which you should be able to find in your plan booklet.

TO ALL MEDICARE PATIENTS: DR. TOMEO IS NOT A MEDICARE PROVIDER. WHICH MEANS THAT DR. TOMEO, AND STAFF WILL NOT SUBMIT A CLAIM FOR MEDICARE, FOR ANY SERVICES FURNISHED TO A MEDICARE BENEFICIARY.

I HAVE READ COMPLETELY AND UNDERSTAND THE ABOVE INFORMATION

____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Dental Insurance
Insurance Comp Name______________________________

Policy holders name____________________ DOB___________

SS of policy holder:____________________

I hereby authorize Charles A Tomeo DMD, to furnish information to my insurance carriers concerning my treatment. I also hereby assign Charles A Tomeo, DMD all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE OF DENTAL POLICY HOLDER ____________________
DATE:

Oral and Maxillofacial Surgery Associates

CHARLES A. TOMEO, D.M.D. CHARLES C. TOMEO, D.M.D.

ADVICE OF FEES AND SERVICE

Dear Patient,

We welcome you as a new patient to our office. We invite you to discuss frankly with us any questions regarding our services or fees. The best medical service is based on a friendly, mutual understanding between the doctor and the patient.

It is the general policy of our office that all professional services rendered are charged to the patient and are ultimately the patient's responsibility. Payment in full is expected on the day of your surgery and for your convenience, we accept cash, personal checks, Visa, Mastercard, Discover, and American Express. However, once services are rendered, any **STOP PAYMENTS** or **CHARGE BACKS** will be in breach of contract and will be prosecuted by the law.

Insurance co-payments and the remaining deductibles are due **PRIOR** to scheduled procedures, any portion of our fee which your insurer fails to pay becomes your responsibility and is payable prior to ninety (90) days from the date services are rendered, interest will accrue at 1½% per month on any balance owed us. Ninety (90) days after the procedure is performed, any amount of our fee outstanding will be turned over to collections including attorney fees and legal costs.

In rare instances, unforeseen, secondary conditions may become evident during the procedure and, in the best judgement of the physician, will require immediate, additional services (i.e.: sinusotomy, cyst removal, biopsy). We will attempt to bill your insurance should this occur, but if they fail to pay, you will be held responsible.

We are pleased you have selected us for your oral and maxillofacial diagnosis and treatment. We will be happy to assist you in every way possible to make your visit with us a pleasant one.

Sincerely,

Charles A. Tomeo, D.M.D., P.A.

FINANCIAL STATEMENT/CONSENT FOR SERVICES

I/We hereby assume financial responsibility for the payment of all charges for services rendered as set forth above. I/We have read and fully understand the terms and policies written herein, and hereby acknowledge receipt of a copy of this agreement.

______________________________ Date______________

PATIENT

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If not Patient, Relationship to Patient

Center for Minimally Invasive Guided Implant Surgery

1906D 59th Street West, Bradenton, FL 34209 / 941/792-0088 • Fax 941/792-4705
1921 Waldemere Street, Suite 807, Sarasota, FL 34239 / 941/917-7700 • Fax 941/917-6230
703A Del Webb Boulevard, Sun City Center, FL 33573 / 813/634-5597