PRESTIGE®
ORAL & FACIAL SURGERY CENTER

5925 CROMO DR. STE. B, EL PASO, TX 79912 P: (915) 283-4730 | F: (915) 283-6210

OFFICE POLICY AND FINANCIAL AGREEMENT

We appreciate that you have chosen our office as your health provider. For the convenience of our patients, we have established an office policy and financial agreement for review.

Dental insurance

As a service to our patients, we will be in the best position to present electronic claims as a courtesy to your insurance.

We may not be a participating provider in your insurance plan. This means that you are responsible for the difference between our rate and the allowed insurance rate. We work with your insurance company to provide you with the most accurate estimate of your co-payments. It is the patient's responsibility to provide the correct insurance information at the first visit. Payment is required at the time of service for all uninsured patients. Insured patients are responsible and must be prepared to pay all amounts that are not covered by the insurance estimate. With insurance plans paying only part of the cost of treatment, we can only estimate what your insurance company will pay. The maximum time allowed for an insurance payment is sixty (60) days. After sixty days, the patient is responsible for the entire balance. We work to help you receive the maximum benefits available under your policy, but we will not be responsible for how your insurance company handles your claims or what benefits you pay in a claim; At no time do we guarantee what your insurance will or will not do with each claim.

Credit cards

We accept Visa, Mastercard, Discover, American Express, and JCB. We offer these to allow you the greatest convenience in the care of your account.

Payment plans

We have decided with Care Credit Company to provide payment plans. This allows you to complete your treatment without delay and make relatively small monthly payments. Credit requests for assistance are available, and approval can be determined in ten minutes. For your convenience, you can submit your application online at www.carecredit.com

Cancellations As a courtesy to all patients, we request that a forty-eight (48) hour notice be given for a canceled appointment. If we have not received sufficient notice, a charge may apply to your account.

DISCLOSURE OF INFORMATION AND ALLOCATION OF BENEFITS

The undersigned in this agreement read the foregoing and accept, whether signed as a responsible or as a patient, to pay our practice full professional fees without regard to insurance coverage. He/She also agree to pay interest on any balance for 90 days from the date of service. In addition, you agree to pay the collection fees, attorneys' fees and court costs in case these means of collection are required.

The undersigned agrees to allow Prestige Oral and Facial Surgery Center to disclose any information requested by the insurance company and to use patient photos (retaining all names) as educational tools within our practice.

Signature of the patient or legal guardian of a minor: _____ Date: _____