Concord Oral Surgery, P.A.
Specialist in Oral & Maxillofacial Surgery

We participate with the following insurance companies:

MEDICAL		DENTAL
Anthem BC/BS	**Federal BC/BS of NH**	**Delta Dental (Premier)**
Cigna HealthCare	**Harvard Pilgrim**	**NH Medicaid**

***If you are covered by an insurance that is not listed above we would be happy to send in a pre-determination of benefits to help determine your out-of-pocket expense.**

It is the responsibility of the subscriber to know the particulars of your insurance policy. **Our office will assist you in any way we can but you are ultimately responsible for any fees that your insurance company does not cover.** Concord Oral Surgery, P.A. will not accept responsibility for negotiating a settlement on a disputed claim. We will do our best to give you an estimate of what your out-of-pocket expense may be based on information gathered from your insurance company; however, information that we obtain from your insurance company is not a guarantee of payment.

Participating Insurance/Non-Participating Insurances: If a procedure is done on the same day as your initial consultation, a co-pay may be due. If you are having a consult first with surgery following at a later date, we will check your benefit coverage and assist you in determining your out-of-pocket expense. This amount will be requested the day of your surgery.

Once your insurance company has responded to the claim for services, we will either bill you for any remaining balance or submit a refund check to you for any overpayment. If there is a remaining balance we request that it be mailed in within 30 days of your statement. We accept MC, VISA, DISCOVER, AMERICAN EXPRESS, and Care Credit.

No Insurance: Requires 100% payment at the time of service.

FINANCIAL UNDERSTANDING AND AUTHORIZATION

I understand that Concord Oral Surgery, P.A. has not offered me any assurance that my dental/medical insurance will pay for all of my care. I understand that Concord Oral Surgery, P.A. may ask my insurance company for a pre-determination of benefits but that I remain responsible for all fees not paid by my insurance. I also understand that the determination of proper treatment, to include the location of such treatment and the choice of anesthetic, is a matter to be decided by the doctor with me (or legal guardian) and is not necessarily based on cost containment or insurance coverage. Understanding this policy statement, I accept financial responsibility to Concord Oral Surgery, P.A. for services rendered. I authorize release of any information relating to this claim. I authorize payment directly to Concord Oral Surgery, P.A. of the insurance benefits otherwise payable to me.

STOP: In signing this form you will be considered the financially responsible guarantor of this bill. All billing statements will be sent to you and it is your name that will be attached to any outstanding balance.

_____	_____	_____
Patient's Name	Signature	Date
_____	_____	_____
Parent or Legal Guardian (if patient is under 18)	Signature	Date

RELEASE OF INFORMATION

I authorize Concord Oral Surgery, P.A. to provide information from records in this office to my dentist, physician, school nurse, or any other specialist involved with my treatment. I also give my consent for information to be released to Concord Oral Surgery, P.A. as it relates to my treatment in this office from my dentist, physician, or other medical specialist involved in my treatment. I am also acknowledging that Concord Oral Surgery, P.A.'s Notice of Privacy Practices was made available to me.

_____	_____	_____
Patient's Name	Signature	Date
_____	_____	_____
Parent or Legal Guardian (if patient is under 18)	Signature	Date