San Francisco Center for Osseointegration
Oral & Maxillofacial Surgery & Implant Dentistry
Christopher A. Gurries, DDS, FACOMS • Edmond Bedrossian, DDS, FACD, FACOMS
450 Sutter Street Suite 2439, San Francisco, CA 94108

FINANCIAL POLICY

We are committed to providing you with the highest quality dental care. If you have dental or medical insurance, we will be happy to answer any questions relating to your insurance and bill on your behalf. However, we need your assistance and your understanding of our payment policy.

As dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, acceptance of insurance assignments does not absolve the patient of **FULL responsibility for charges for treatment rendered.** If we fail to receive a response from your insurance company within 30 days, or if your claim is denied payment, you will be responsible for payment of the account in full.

Please understand that not all services are a covered benefit in all contracts and no insurance company pays 100% on claims submitted. Therefore, if you have insurance you will be required to pay an ESTIMATED PORTION of the bill at the time services are rendered (this amount can vary depending on your insurance coverage and the maximum amount of coverage remaining for the year). Once your insurance pays, your account will be reconciled and you will be billed for the balance or sent a check from our office for the overpayment.

Payment for services is required at the time services are rendered. We accept cash, checks, debit cards, Visa, Mastercard, and American Express. No surcharge applies to payments made by cash, check, or debit card. Credit card payments are subject to a surcharge of up to 3%, depending on the payment method, but not to exceed our applicable cost of credit card acceptance. The applicable surcharge will be disclosed prior to payment.

Any accounts with balances over 30 days old will be subject to a 1.5% monthly finance charge (18% annual rate).

Any returned checks are subject to a $10.00 service charge plus any bank fees incurred.

Payments refunded at the patient's request may be subject to deduction of non-refundable credit card processing fees charged to the practice.

APPOINTMENT CANCELLATION / NO-SHOW POLICY

Your appointment time is reserved specifically for you. We understand that schedules change; however, late cancellations and missed appointments prevent us from offering that time to other patients.

Consultation and Evaluation appointments: Cancellations with less than 24 business hours' notice, or failure to attend a scheduled appointment, may be subject to a **$100 cancellation/no-show fee.**

Surgical appointments: Cancellations with less than 48 business hours' notice, or failure to attend a scheduled surgical appointment, may be subject to a **$250 cancellation/no-show fee.**

We understand that emergencies and unexpected circumstances occur. The practice may waive a cancellation or no-show fee at its discretion. Cancellation/no-show fees are the patient's responsibility and are not billed to insurance. Any outstanding cancellation/no-show fee may be required to be paid before another elective appointment is scheduled.

For surgical appointments, the practice may require a valid credit card to secure the reserved surgical time. If a card-on-file authorization is obtained, the applicable cancellation/no-show fee may be charged to the authorized card in accordance with that authorization and this policy.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us, we are here to help you.

"I have read and understand the financial arrangement, including the appointment cancellation/no-show policy."

***Patient's Signature:*_____ *Date:*_____**

***Patient's Name:*_____**