Oral and Facial Surgery Institute of Houston
Patient Registration

4724 Sweetwater Blvd #105 Sugar Land, TX 77479
Phone: (281) 491-4545, Fax: (281) 491-7134

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.

2. If you have a change of address, telephone numbers, or employer, please notify the receptionist and we will give you a form to update.

3. We will collect your deductible, co-payment or charge from non-covered services at the time of the visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept Cash, Visa, Master Card, Discover and American Express and Master Card and Visa Check Cards. **NO PERSONAL CHECKS.**

4. **REGULAR INSURANCE:** We will file your claim as a courtesy. We cannot guarantee payment by your insurance company and any portion collected is only an **ESTIMATE.** You will be expected to follow-up make sure payment is made to us in a timely manner. If we do not receive payment within 30 days, you will be billed for an unpaid balance. If your insurance denies our charges, or does not pay us in a timely manner, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our office to make payment arrangements. If you do not pay on time, your account may be referred to a collection agency and reported to the credit bureau.

5. Effective January 1, 2000, we will assess a 1.50 monthly interest on unpaid balances over 60 days old.

6. **HMO-PPO PATIENTS:** If we participate with your plan, you will bill your insurance for you. Your co-payment will be collected at the time of service—no exceptions. If your plan requires you to have an authorization to see a specialist, you will need to obtain that **Referral** prior to seeing the specialist. No retroactive consideration will be given. If we participate with your plan, we will verify your out-of-network benefits, files your charges, and will expect payment of your portion of the charges at the time of service.

7. **SELF - PAY PATIENTS:** Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you may make payment arrangements, via an approved credit plan, prior to services rendered.

8. **MEDICAID PATIENTS:** Picture ID and a current Medicaid letter is required.

9. **NO SHOW OR MISSED APPOINTMENTS:** We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 24-hour notice of cancellation by you. If an appointment is missed without cancellation or failure to show, you will be charged a $25.00 fee.

**Important Notice: with or without insurance, you are ultimately financially responsible for payment of charges for services rendered.**

I have read and have a full understanding of the financial policy of Oral and Facial Surgery Institute of Houston.

Signature of Patient ___________________________ Date __/__/__________
Signature of Parent or guardian