Wood & Myers
Oral & Maxillofacial Surgeons

# FINANCIAL POLICY

Wood & Myers Oral & Maxillofacial Surgeons ("Wood & Myers OMS") is committed to providing you with the best possible care with a clear understanding of our financial policy. We are happy to discuss our professional fees with you at any time, please ask if you have any questions about our fees, financial policy, or your financial responsibility.

**PLEASE REVIEW AND INITIAL EACH PARAGRAPH BELOW:**

## A. INSURANCE:

_____1. I understand that it is my responsibility to know the limits and coverages of my medical and/or dental insurance. I understand that it is important that I bring my current medical and dental insurance card(s) with me to each visit, and I agree to do so.

_____2. I am aware that some or all of the services rendered to me by Wood & Myers OMS may or may not be covered by my insurance policy or policies, and that it is up to me to contact my insurance company in order to accurately identify my benefits and payment obligations under the policy. I understand that as a courtesy, Wood & Myers OMS will coordinate with my insurance company to try and provide me with an accurate estimate of my payment obligations for my treatment, including but not limited to any applicable co-pays and deductibles.

_____3. I understand that if I have no insurance which covers the services I am receiving, full payment for the service will be due at the time of service.

_____4. I understand that if my insurance does not cover a portion of the services I am receiving, full payment of my payment obligations under my insurance policy is due at the time of service. I understand that if I am unable to comply, my service will need to be rescheduled.

_____5. I understand that if I do not have medical and/or dental insurance which covers my treatment, Wood & Myers OMS will require payment in full at the time of service. I understand that if I am unable to comply, my service will need to be rescheduled.

_____6. I understand that Wood & Myers OMS accepts cash, checks, Visa, MasterCard, American Express, Discover and Care Credit for payment of my payment obligations.

_____7. Notwithstanding the above, I understand that if I am self-pay or uninsured for the services I receive from Wood & Myers, that Wood & Myers will provide me with a Good Faith Estimate for those services in advance of the appointment at which the services will be provided, as required by law.

**B. BILLING:**

_____1. I understand that I will also be invoiced for any reasonable and necessary additional services rendered to me by the providers at Wood & Myers OMS which were not initially contemplated.

_____2. I understand that to the extent permitted by my insurance policy; I will also be invoiced for any services provided by Wood & Myers OMS if my insurance company does not pay any part of a previously estimated amount.

_____3. I understand that statements will be generated every 30 days, that payment is due within 30 (thirty) days of the date of the statement, and that a monthly late fee of 1.5% of the amount due will be assessed for any outstanding balances not received by Wood & Myers OMS within five business days of the due date.

_____4. I understand that the collections process will be initiated for any outstanding balances 90 days or more past due, and a 30% collection fee will be added to my amount due. I understand that I will be responsible for reimbursing Wood & Myers OMS for any legal fees incurred in the pursuit of the collection of any past due amounts.

_____5. I understand that a returned check fee of $50 will be added to my account if any personal check submitted in payment of my payment obligation for services rendered is returned as unpaid by my bank. If this occurs, I understand that Wood & Myers OMS reserves the right to require cash payments for my outstanding payment obligations.

_____6. I understand that any credit balance on my account will be reimbursed to me in a timely manner, usually within 90 days after my treatment has been completed and all applicable insurances have been properly billed and remitted all payments due.

_____7. I understand that if I am more than 15 minutes late for my appointment, it may be necessary to reschedule my appointment, and I may incur a cancellation/rescheduling fee as further set forth herein.

_____8. I understand that I can always call the Wood & Myers OMS billing office at 717-763-1970 ext. 196 (Billing) with any questions or concerns I have about any aspect of this Financial Policy.

C. **CANCELLATION/RESCHEDULING FEES:**

_____1. I understand that I will be charged a $100.00 cancellation fee if I miss or cancel my first appointment with less than 48 hours notice.

2. I understand if I cancel any appointment with less than 48 hours notice or if my appointment needs to be rescheduled as set forth in Sections A and B above, this represents a cost to Wood & Myers and to other patients who could have been treated in the time set aside for me. I understand that I may be charged a cancellation/rescheduling fee of $100 under such circumstances, and that I may be required to pay such fee before my appointment or treatment will be rescheduled.

3. I understand that repeat cancellations and/or lateness for appointments may result in dismissal from the practice.

THE SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF FINANCIAL INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE PAYMENT TO WOOD & MYERS, AND/OR MY DOCTOR RENDERING SERVICE AND/OR TREATMENT.

X _____ X _____

Signature Date

_____

Print Name



13427871.1

13497945.1

10.24.25

13427871.1

13497945.1

10.24.25