Oral & Maxillofacial Surgery

Fellow
American Association of
Oral & Maxillofacial Surgeons

Jeffrey N. Kenney, D.D.S.
Diplomat, American Board of
Oral & Maxillofacial Surgery

WRITTEN FINANCIAL POLICY

Thank you for choosing Dr. Jeff Kenney, D.D.S. Oral & Maxillofacial Surgery. This document outlines our billing process and the payment options available in this office.

- Cash/Check/Money Order
- Credit Cards (Visa, MasterCard, Discover & American Express)
- Care Credit

Payment is required prior to treatment. If you choose to discontinue care before treatment is complete, you will receive a refund *LESS* the cost of care/treatment already received. Refunds will be issued to the patient/guarantor responsible for the account.

For patients with insurance, we will work with the insurance carrier to obtain information regarding benefits. Our billing office will bill your insurance company directly for reimbursement for treatment. You (the patient or the responsible party thereto) will be given an *ESTIMATE* of charges which will include what we *ESTIMATE* the coverage will be. Please note: THIS IS AN *ESTIMATE* ONLY. We provide this estimate as a courtesy and suggest you contact your insurance carrier to inquire about *your* specific benefits. Our estimates are based on information we obtain regarding benefits from your insurance carrier and are not guaranteed for payment. You are ultimately responsible for any costs not covered by your insurance. If we have not received payment within 90 days after billing the insurance, we reserve the right to bill you (the patient or the responsible party thereto).

INSURANCE WAIVER

Your insurance may not pay for items or services listed below. Insurance pays for services based on minimal plan provisions and may not cover services that are reasonable and necessary for your health.

- CBCT
- IV Drugs for Nausea, Infection, Swelling
- Dental Implants
- Sedation
- IV Supplies
- Other _____
- Nitrous Oxide
- Bone Grafting

The total charge for these non-covered services will be added to the estimate of charges provided to you.

NOTICE OF NON-COVERED SERVICES:

Insurance carriers will only pay for services that are covered by *your* particular plan. You are responsible for any balance on your account, including balances resulting from insurance misquotes, excluded services, waived items, and non-covered services. Your treatment plan may contain a recommendation(s) and/or you may require a procedure(s) that is not a covered benefit with your insurance carrier. You (the patient or guarantor) are fully responsible for any and all charges denied by your insurance company for services rendered. Your treatment plan may require and/or you may opt for a procedure that is not a covered benefit with your insurance carrier. You (the patient or guarantor) are fully responsible for all charges denied by your insurance company for all services rendered.

ACKNOWLEDGMENT:

By signing below, I acknowledge that I have read this office's Financial Policy. Further, I give my consent to be contacted by mail, email, text message, or phone regarding any matter related to the above-referenced account by the creditor, its successors or assignees. This consent includes any updated or additional contact information that I may provide and includes calls that employ auto-dialer technology and prerecorded message if an account is not paid.

_____	_____	_____
Patient, Parent or Guardian (SIGNATURE)	Patient Name PRINT	DATE

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