Leavenworth Oral and Maxillofacial Surgery

Financial Policy

Thank you for choosing Leavenworth Oral and Maxillofacial Surgery as your oral surgery provider. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and as manageable for our patients as possible by offering several payment options, which are listed below.

Payment Options:

1. Cash
2. Check
3. Visa®, MasterCard®, Discover Card®, or American Express® **We impose a 2% surcharge on the transaction amount on all credit card payments, which is not greater than our cost of acceptance. We do not charge this fee on debit cards or HSA/FSA cards.**
4. Convenient Monthly Payment Options[1] from Care Credit Healthcare Credit Card
   - Allows you to pay over a period of time
   - No annual fees or pre-payment penalties

Leavenworth Oral and Maxillofacial Surgery require payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

Services rendered are fully the financial responsibility of the patient or account guarantor. ***As a courtesy, we will work with your insurance carrier (if applicable) to maximize your benefit for treatment reimbursement***. Any outstanding balance on the account is the patient's responsibility. Should the insurance company send payment to the policy holder, payment must be forwarded to our clinic within 48 hours.

A fee of $50 is charged for patients who miss or cancel surgery appointments without 48-hour notice.

Leavenworth Oral and Maxillofacial Surgery charges $60 for returned checks.

Upon failure to provide payment for rendered service, three attempts will be made by our clinic to request payment. If no payment is received after the third attempt, the patient's account will be submitted to the collections process; any cost incurred by our clinic to retrieve the overdue balance will be the patient's responsibility.

Any violation of this agreement will, at the provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.