Chesapeake
Oral Surgery & Dental Implants

2360 W. Joppa Road, Suite 310
Lutherville, MD, 21093

2027 Pulaski Hwy, Suite 113
Havre de Grace, MD 21078

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410.670.4500

Financial Policy

Basic Policy Date: ______________

Payment for services is due in full before treatment is started. **Our office accepts cash, debit cards, credit cards, cashier's check, and money order made to the practice**. We also offer third party financing (Care Credit). A down payment of 50% of the total fee will be collected to schedule any service over $1,500. We accept personal checks with a valid ID as down payment for scheduling surgery. There is a $35.00 charge for returned checks. **Please be advised there is a fee for consultations.**

For Patients with Dental Insurance

As a service to you, and as long as we are provided the necessary paperwork, we will bill your insurance carrier. We will assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims**. *Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but you are ultimately responsibility for any unpaid balance.*** Please understand that insurance is a contract between you (your employer) and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees will be due and payable in full from you. If you are experiencing any financial difficulties, please contact our office to discuss payment options.

For Patients with Medicare and / or Medical insurance

Medicare does not cover dental procedures. We do not participate with Medicare and medical insurance. You will be responsible for all expenses for these services. Our office will not be responsible for submitting paper work or forms to Medicare or any medical insurance.

Surgery Fees

All copayments, deductibles and payments for non-covered surgical procedures are due on the day of surgery. Your insurance carrier may require a pre-determination of benefits for the surgery. ***The Pre-determination is not a guarantee of payment***. Insurance companies may deny claims even when a pre-determination has been submitted. Our fee schedule is based on the time, quality of care and the expense of the supplies in order to provide the highest standard of care.

Pathology Specimen

When a pathology specimen is submitted to an outside lab (e.g. Lab Corp, Quest Diagnostics, University of Maryland Dental School) for a biopsy procedure, whether alone or in combination with another procedure (for example, a cyst associated with a tooth), you will receive a separate billing statement from an outside lab for the examination and the report of the specimen. We are unable to determine the cost of the lab bill. Our pre-treatment estimate only reflects the surgery portion of the fee, not the pathology report. Please contact the pathology lab directly to inquire about their billing statement. We will send a copy of your medical insurance card to the lab.

Hospital Outpatient Surgery

For outpatient surgery schedules in the hospital, our pre-treatment estimate only reflects the surgery portion, *not* the anesthesia or facility fee. Please contact the hospital directly regarding their billing statements.

Missed Appointments

We require a 48 hour notice if you are unable to keep your scheduled appointment. If you do not notify us, there will be a $100 missed appointment fee.

Outstanding Balance Policy
Past due accounts are sent two statements. If payment is not made on the account, a single phone call will be made to collect payment. If no payment is made, the account will be sent to an attorney for collection. Past due accounts could result in discharge from the practice.
In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.
Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I have read, understood, and agree to the above financial policy for payment of the professional fees. I understand that I am ultimately responsible for all fees for services provided to me.

Patient's Name (Please Print): ______________________________________ Guarantor/Patient's signature: __________________________________