Dear Patient:

This letter is to inform you of the financial risks involved in your insurance plan. It is the doctor's responsibility to recommend and provide to you the best health care services.

You are responsible for the cost of the health care provided. Reimbursements from your insurance contract are between you and your insurance carrier. It is your responsibility to maintain eligibility and inform us of any changes.

Our office will give you an estimate of costs for the recommended services, but these are estimates only. You as the patients have two options.

1. Our office can contact your insurance and receive benefits and coverage over the phone with the understanding that the co-share given is just an estimate. Your financial obligation for services rendered may be more or less once the insurance has processed the claim. ****Any outstanding balance will incur 10% finance charge if not paid in full within 10 days.*

2. Our office can submit a pre-determination/pre-authorization request to your insurance and wait for them to process the request and forward the explanation of benefits with your co-share.

X-RAYS - If x-rays are needed for your treatment, please let us know if you have recent x-rays prior to allowing us to take the x-ray. Your x-rays may not be covered by your insurance and you may be your financial responsibility.

_____(initials) I have read and understand my financial obligation for services rendered.

Please be advised that there will be a $20.00 fee charged for appointments that are cancelled without 24 hours advance notice to our office. If a surgical appointment is cancelled without at least 48 hours' notice, whether it is scheduled in the office or at a hospital, you will be charged 10% of the total procedure charges. All return checks will be charged a minimum $35.00 return fee.

By signing this document, you are stating that you fully understand the above information.

Notice of Privacy Practices for Protected Health Information

Chula Vista Oral and Maxillofacial Surgery Center HIPAA

I, _____ (Patient Name), hereby acknowledge that I have read and have the option to receive a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of responsible party

X _____ Date: _____

Print Name: _____ circle one: Patient Parent/Guardian other