ROBERT C. KUEPPER, D.D.S.
ORAL & MAXILLOFACIAL SURGERY
FINANCIAL FORM

Dear Patient:

We believe that every patient is entitled to the highest quality of oral and maxillofacial surgical care that can be provided. Your health and well-being are our primary concerns. We appreciate the consideration you must give to the cost of your care. We encourage you to be familiar with your insurance coverage, and we welcome frank discussions of services and fees **prior to treatment** to avoid any misunderstanding about the cost of your care.

This practice accepts patients regardless of your medical and/or dental insurance benefits. You should check with your medical primary care physician to determine if you need a referral to our practice.

We are happy to prepare and submit claim forms to your insurance companies; however**, all patients are ultimately responsible for any fees that their insurance does not cover. We will not be responsible for collecting payments due from insurance or for negotiating a settlement on a disputed claim.**

Payment is due at the time of service. If you have insurance, the amount due from you depends on your policy and coverage. It is the patient's responsibility to understand his/her insurance benefits.

Participating Insurance: Northeast Delta Dental, All Delta USA, Premiere & Preferred Dental Plans, Harvard Pilgrim, CIGNA and Anthem BC/BS medical insurances.	**Requires a deposit at the time of service.** This deposit will be based on your policy and the services being rendered. Any remaining balance must be paid within 30 days after the date of service. If an insurance payment exceeds the amount due, a refund will be made to you.
No insurance and Non-Participating Insurance.	**Requires 100% payment at the time services are rendered.**
Payment Options:	**Cash, Check, Money Order, MasterCard/VISA/American Express/ Discover and CareCredit.**

PLEASE TURN PAGE OVER TO SIGN FINANCIAL POLICY

FINANCIAL UNDERSTANDING

I understand that this office has not offered me any assurances or determination that my medical/dental insurance will pay for any or all of my care**. I understand that I may ask my insurance company for a pretreatment estimate of benefits, but that I remain responsible for all fees not paid by my insurance.**

I also understand that the determination of proper treatment and the choice of anesthetic, are matters to be decided by the doctor with me (or legal guardian), and these decisions may not be based upon cost containment or insurance coverage. Understanding these facts, I accept financial responsibility for the services provided to me by Dr. Kuepper.

______________________________	________________________	_________
Legal signature of Patient or Legal Guardian, Guarantor or Person authorized by law	Name of Patient	Date

I authorize the release of any information related to insurance claims submitted on my behalf to the insurance company. I also authorize Robert C. Kuepper, D.D.S. to provide information from my records in this office to my dentist, physician and/or referring doctor.

______________________________	________________________	________
Legal signature of Patient or Legal Guardian, Guarantor or Person authorized by law	Name of Patient	Date

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