Neal A. Zabiegalski, D.D.S., P.C.

Diplomate of the American Board of Oral and Maxillofacial Surgery

2525 Riva Rd. #122
Annapolis, Md. 21404
Phone: (410) 224-4952

22926 Three Notch Rd. #103
California, Md. 20619
Phone: (301) 862-5600

Financial Agreement

Thank you for choosing our practice for your oral surgery needs. We are committed to providing a professional and caring atmosphere for our patients and we will do everything we can to make sure your visit with us is a pleasant one.

As a **courtesy** to our patients who have insurance, we are happy to file an insurance claim for you at no additional charge. However, the contract that you have with your insurance company is a contract between **you and your insurance company.** Ultimately, you are responsible for payment to be made for services rendered. We ask that you bring your insurance cards with you (both Medical and Dental). During your initial evaluation/consultation (charge will vary) you will be given an estimate of charges for your surgery. On the day of surgery, it is *our office policy* that you pay a portion of the total amount for the surgery. This portion is **only an estimate** of your expected co-insurance after insurance pays. These amounts are based on information we receive from your insurance but are not a guarantee of payment of any kind until after the services have been rendered. Again, this is **only an estimate** and the amount you pay is **only a portion of the total surgery cost.** If once your insurance company pays, you have a credit on your account then we will refund that amount back to you. On the other hand, if you have a balance then we will send a statement to you in the mail. This balance is expected to be paid in 30 days from the insurance payment date. Regardless of who pays, **all accounts are to be paid in full within 90 days from the date services were rendered.** Services charges will start to accrue automatically after 90 days if there is a past due balance.

For patients that do not have insurance or have medical insurance only, **full payment** is expected on each date of service. Estimates given prior to being seen by the doctor are **only estimates.** Once you have been seen by the doctor, our financial coordinator will be able to give you an estimate of total surgical costs.

For any treatment that charges total $260.00 or less and services are rendered the same day as the consultation, we require that the amount be **paid in full** at the time of service.

We appreciate your cooperation with our financial policies. Please make sure you have read this full agreement before signing.

"I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL AGREEMENT"

Patient/Guarantor Signature: _____ Date: _____

Staff Witness: _____ Date: _____