UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Surgery
Oral and Maxillofacial Surgery

Outpatient Clinic Financial Policy

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Thank you for choosing our practice as your health care provider. Your clear understanding of our financial policy is important to our professional relationship. Please speak with our Billing receptionist if you have any questions.

1. Payment of anticipated patient responsibilities is required at the time services are rendered unless other arrangements have been made in advance. Such payments include co-insurance, co-payments, deductibles, and non-covered services. If the patient is a minor, the parent/guardian is the responsible party. This payment may be required before your service is performed.
2. If we are a "contracted" provider of services for your insurance company, we will file charges for you. However, anticipated financial responsibilities are defined through the contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims as insurance companies only "quote" benefits; they never "guarantee" benefits. Ultimately, the patient is responsible for knowing their carrier contract exclusions, benefits and co-insurance, deductible or co-pay provisions.
3. It is your responsibility to make sure we have your current insurance information so that we may correctly file your claims according to timely filing limitations. If we are not "contracted" with your insurance company, you will be required to pay in full at the time of service. If you are seeing an oral surgeon or expect your medical carrier to cover dental services, we must have both your medical and dental insurances verified prior to seeing the provider. Failing to provide this information will delay your care and can lead to higher patient costs.
4. If you are on an insurance plan that requires a referral, it is your responsibility to obtain it and bring it to each visit. The referral must be requested from your primary care physician prior to your appointment in order for insurance to be filed. If you do not have the referral, your visit may be rescheduled or you may have to pay for services provided.
5. Missed appointments represent a cost to us, you, and other patients who could have been seen in your reserved time. Cancellations are requested 48 hours prior to the appointment. If you are a new patient, the first missed/cancelled appointment within 48 hours or more than 20 minutes late after your anticipated arrival time, you may receive a warning letter from the Clinic Manager. If you are an existing patient and you miss/cancel two appointments within 48 hours or by being more than 20 minutes late, you may receive a warning letter from the Clinic Manager. If missed appointments continue after the warning letter is sent, your care at our clinic may be terminated.
6. All medical record requests use an "Authorization to Disclose Protected Health Information" form. You may call Health Information Management at **214-648-2498** for medical records or duplication of dental x-rays.
7. All prosthetic devices and all dental appliances require a 50% down payment of the patient responsibility at the time the impression is taken. This is to ensure lab costs are covered. The remaining 50% patient responsibility is due at the time the device is delivered to you. ******For orthodontic contracts, please speak to the billing Clinic Staff Assistant, Clinic Staff Supervisor, or Clinic Manager for its provisions.******
8. If an impression for any oral device is taken and 50% of the anticipated costs are not paid, the impression will be held until such time payment is available. If no payment is obtained in 3 months, the impression must be destroyed, as it may no longer represent the oral condition. Once ordered, no more than 50% of the cost can ever be credited or refunded, even if the product is destroyed after 6 months, again due to the changing status of the oral condition.
9. If you purchase any products from our inventory (bleaching supplies, oral rinse), these products are non-refundable once they are opened.
10. Medicare, Medicaid, and other payors may not pay 100% of your bill. Some of these carriers still require patient participation in the expenses. Further, if these entities reject your claim as a non-covered service, you or your guarantor will be held financially responsible.
11. All pre-estimates are approximations only and can in no way guarantee the specific coverage from your insurance company. Other care may be needed at the eventual time care is rendered. We complete these pre-estimates as a courtesy to you, with the hope that you have an idea of the potential financial liability.

I have read and understand the financial policy of the Oral and Maxillofacial Surgery Clinic (OMS) at UT Southwestern Medical Center. I agree that, if it becomes necessary, my outstanding balances may be referred to a collection agency, and my status as a patient of the OMS clinic may be terminated.

Patient's Printed Name	Patient's Signature	Date
Legal Representative's Name*	Legal Representative's Signature	Date

*Proof of status as legal representative may be required.

Form # SYR/OCFP-001 / 08.05 Original – Health Information Management Department Copy – Patient