JON R. EWIG, D.D.S.
ORAL & MAXILLOFACIAL SURGERY
3585 Wendleton Lane
Beavercreek, Ohio 45432

FINANCIAL POLICY

The relationship between you and your doctor is unique and is based upon mutual trust and respect. Every successful relationship requires that both people assume responsibilities. You have a right to expect that Dr. Ewig and his staff will provide the finest possible care available. We take this obligation seriously. Payment for this care is one of your responsibilities as part of this relationship. Please read this carefully. Be sure to ask any questions you may have. Your signature at the bottom of this page indicates your clear understanding of our financial policies and your obligations.

- Full payment is due at the time of service unless prior arrangements have been made. I understand that I am completely responsible for all charges incurred by me for services rendered in caring for my oral and maxillofacial needs.
- We accept cash, checks, Visa, MasterCard and Discover.
- Outside financing through Care Credit or Springstone.

MINOR OR DEPENDENT CHILDREN

Minor and/or dependent children (under 18 years of age) must be accompanied by a parent or legal guardian. The adult accompanying the child/dependent will be held financially responsible for all fees incurred, regardless of his/her marital status or custody issues regarding the child dependent.

REGARDING INSURANCE

Insurance plans vary greatly and your policy may have exclusions and gaps in coverage for certain services.

To submit a claim for you we **MUST** have:

- Supply a CURRENT form of insurance card with address, phone, ID and group number, or fill out the information in full on the back of this form.
- In general, for treatment totaling $300 or less, the full amount is due at the time of service. On the day of treatment an estimate of your financial responsibility will be collected. An estimate can only be given if complete and accurate information is provided. If you do not have an insurance card, please contact your dental office to complete the "Insured Information" section.
- It is **YOUR RESPONSIBILITY** to know who your insurance carrier is and what they **DO/DO NOT COVER.**
- Please understand, you are responsible for the balance if your insurance company does not pay within 90 days. It is important that you keep in contact with your insurance until your claim has been paid.

As your oral surgeon, Dr. Ewig promises not to allow your insurance to influence those decisions involving the need, timing, or cost of your treatment. These important decisions will be based solely on what Dr. Ewig believes to be in your best interest and only with your full consent.

AGREEMENT

I have read and understand this policy statement and my questions concerning it have been answered. I agree to comply with all aspects of this policy. **I agree to be financially responsible for any balance remaining after payment of possible insurance benefits.** In the event that I do not pay all of my charges, I authorize Jon R. Ewig, D.D.S., Inc., to disclose my diagnosis and treatment records to any billing agency, attorney, or debt collection agency.

Patient/Guardian Signature _____ _____

Please Print

I authorize payment of medical/dental benefits to this office for services rendered to me and authorize the release of any medical information necessary to process this claim.

Patient/Guardian Signature _____

I have been given the opportunity to read and receive this office's Notice of Privacy Practices.

Patient/Guardian Signature _____

OVER PLEASE

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # Home _____ Work _____ Ext _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ EMPLOYER ADDRESS _____

INSURED INFORMATION

PRIMARY INSURANCE

INSURED NAME _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

WORK PHONE _____ EXT _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

EMPLOYER _____

EMPLOYER ADDRESS _____

_____

INSURANCE NAME _____

ADDRESS _____

_____

PHONE _____

POLICY # _____

GROUP # _____

SECONDARY INSURANCE

INSURED NAME _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

WORK PHONE _____ EXT _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

EMPLOYER _____

EMPLOYER ADDRESS _____

_____

INSURANCE NAME _____

ADDRESS _____

_____

PHONE _____

POLICY # _____

GROUP # _____