SOUTHWEST

ORAL FACIAL & IMPLANT SURGERY

Dr. Erik J. Nielsen Dr. Matthew K. Mizukawa Dr. John H. Mizukawa

FINANCIAL AGREEMENT

We are pleased to have you as our patient and appreciate the confidence you have shown in our office. It is our goal to offer exceptional professional care and customer service.

An estimate will be given to you of the charges for any procedure or surgery you plan to undergo prior to start of treatment. **Payment is due at or before time of service** and we offer the following options:

1) We accept cash or check.

2) We accept all major credit cards.

3) We will assist you with an application for financing through Care Credit. This option offers up to 12 months interest-free financing or longer term financing with interest. Please ask our staff for assistance in applying, notification is immediate. Care Credit can also cover any remaining balance after insurance pays if the application was completed at time of service.

4) We accept most dental insurances. As a courtesy to you, we will submit your claim to your insurance company. Please note however, that depending upon the company you or your employer contracted, your dental insurance may only provide coverage for a limited number of basic services. Some companies pay fixed allowances for certain procedures while others pay a percentage of their allowable charge.
   A down payment will be required at time of service based on procedures pre-identified as outside the scope of benefits. Regardless of the portion of your bill paid by your carrier, you will retain responsibility for the final amount due. To submit a claim for you, we require the following information: Name of Insured, Date of Birth, Insured's Employer and Group Number, Insured's Social Security Number and ID Number, and Name, Address and Phone Number of Insurance Company.

If for any reason an unpaid balance should proceed beyond 90 days, a monthly service charge of 1.5% (18% per annum) will be applied.

In the event this account goes to Collection, I understand that I am responsible to pay Collection fees of an additional 33.3% of the outstanding amount of my account balance. In addition to this, I am responsible to pay all court costs and reasonable attorney fees required to collect monies owed by me that may be assessed to Dixie Oral Maxillofacial and Implant Surgery by any agency retained to pursue the matter.

There can be a $50.00 charge or more for missed or canceled appointments with less than a 24 hour notice.

I have read the above information and agree to the terms outlined herein.

_____Signature of Patient or Responsible Party (must be over 18 years of age) Date