Michael L. La Puma, D.M.D.
Oral and Maxillofacial Surgery

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FINANCIAL POLICY TERMS and RECEIPT OF PRIVACY POLICY

Thank you for choosing us as provider members of your health care team. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. We require you read and sign our terms prior to any treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.
WE OFFER AN EXTENDED PAYMENT PLAN THROUGH CARE CREDIT.

Insurance:
We are in network for Delta Dental and out of network for all other insurance companies. As a courtesy, we can preauthorize on request only and will bill rendered treatment given the correct information within 90 days of your visit. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Medicare:
Our office has no relation with MEDICARE and neither accepts nor bills MEDICARE insurance.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Fees are subject to change without prior notice.

Adult Patients: Adult patients are responsible for payment at the time of service.
Minor Patients: A parent or guardian must accompany minors. The parent or guardian is responsible for payment. For unaccompanied minors, treatment will be denied.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

I have read and understand the Financial Policy. I agree to the Financial Policy terms.

_____ _____ _____
Print Name Signature Date

I acknowledge I have received the Patient Privacy Policy of Michael L. La Puma, D.M.D

_____ _____ _____
Print Name Signature Date