ALAN L. PEET, DDS, PLLC
STEPHEN TURELLA, DMD
DIPLOMATE OF THE AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY

FINANCIAL INFORMATION/POLICY

We are pleased that you have chosen our office for your oral surgery care. It is our goal to make this a comfortable and positive experience for you. Our financial policy is designed so that you and our office will have a clear understanding of your financial commitments prior to surgery, and so we can have an agreement of terms of payment that will work for both of us.

The patient or parent/guardian is responsible for this account, regardless of insurance coverage. We do not accept insurance as payment in full, but will handle the submission of all claims as a courtesy to you. We request that all accounts be paid in full within 30 days, unless other specific arrangements have been made prior to date of service.

Statements are mailed to all patients (regardless of insurance coverage). **All accounts over 90 days old will have a service charge added to the unpaid balance each month.** Missed monthly payments may be subjected to a $15 late fee.

PAYMENT PLANS:

1) Payment in full on the day of service. We accept cash, check or Visa/Mastercard, Discover.

2) We also offer payment plans through CareCredit. Ask for details.

3) Verified insurance coverage: Authorized release of any information relating to my claim, to the insurance carrier(s), listed on the reverse of this form. Contract benefits will be paid directly to the provider. The patient will pay their percentage on the day of service (not less than 20%). The balance will be due in 30 days by either the insurance company or the patient.

Appointments cancelled with less than 24 hours notice may be subject to a $100 fee!

A $25 dollar returned check fee will be assessed on any NSF checks written on your account.

This certifies that the information/history given is correct. I understand the terms and agree to fulfill my financial commitment with this office.

Signature: _____ Name (please print):_____

Date: _____

OLYMPIC PENINSULA ORAL SURGERY & IMPLANTS
550 North 5th Avenue, Sequim, WA 98382 **(360)681-0900** Fax: (360) 681-0875
902 E. 8th Street, Port Angeles, WA 98362 **(360)457-9470** Fax: (360) 457-6966

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Patient Information

Patient Name: _____ Social Security #: _____
Address: _____ City: _____ Zip Code:_____ Date of Birth:_____
Home/Cell Phone: _____ Work Phone: _____ Emergency phone: _____
Employer: _____ Address: _____
Spouse's Name: _____ Employer:_____
Student: Y N School: _____ City: _____

Financially Responsible Party Information:

Name: _____ Relationship:_____
Billing Address: _____
Home Phone:_____ Work phone: _____ Other: _____
Social Security #_____ Insurance coverage? (Circle) No Yes (Continue)

Insurance Coverage Information:

Primary Insurance Company: _____ Circle one: Medical Dental
Claims address: _____ Phone: _____
Subscriber's Name: _____ Employer: _____
Subscriber's SS#: _____ Group #_____ Birthdate: _____

Secondary Insurance Company: _____ Circle one: Medical Dental
Claims address: _____ Phone: _____
Subscriber's Name: _____ Employer: _____
Subscriber's SS#: _____ Group #_____ Birthdate: _____

Additional Insurance Company: _____ Circle one: Medical Dental
Claims address: _____ Phone: _____
Subscriber's Name: _____ Employer: _____
Subscriber's SS#: _____ Group #_____ Birthdate: _____

(Over Please)

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