Offices of Heather Bond Southard, DDS

PATIENT FINANCIAL RESPONSIBILITY

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
    - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered services.
    - Co-payments are due at the time of services.
    - Patient outstanding balances are due when you check in for your appointment.
    - If my plan **requires a referral,** I must obtain it prior to my visit.
    - In the event that my health plan determines a services to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to pay for the medical services rendered to me at the time of services, including all surgeries.
2. **SELF-PAY ACCOUNTS**

    Our office designates accounts, Self-Pay, under the following circumstances:

    1. A patient is covered by an insurance plan that our providers do not participate in.
    2. A patient does not have a current, valid insurance on file.
    3. A patient does not have a valid insurance referral on file.
    4. A patient does not have insurance coverage.
3. **PRIMARY CARE PHYSICIAN AND REFERRALS**

    If you are a TMJ patient and your insurance plan has a designated primary care physician and you are required to obtain a written referral from that doctor, you must provide our office with that referral at the time of check in. If you do not have a current, valid referral, we may ask you to reschedule your appointment.
4. **AUTHORIZATION TO RELEASE RECORDS**

    I herby authorize the **Offices of Heather Bond Southard, DDS** to release to my insurer, governmental agencies, or any other entity financially responsible for my dental/medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such dental/medical services as well as information required for precertification, authorization or referral to other dental/medical providers.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Responsible Party Date