New Canaan & Westport Oral & Maxillofacial Surgery
Philip F. Pacelli, D.M.D., M.D.

Dear Patient: WELCOME TO OUR OFFICE.

Please be advised that Dr. Pacelli does not participate with any medical or dental insurance plans. Payment in full is due on the day of your visit.

In an effort to provide you with a flexible payment option, we accept the following methods of payment: Visa, Master Card, Cash or personalized checks. There will be a $25.00 fee incurred for any insufficient check posted.

HOURS OF OPERATION: Monday, Tuesday, Thursday, and Friday from 8 am – 5 pm. Wednesday from 8 am - noon. All patients seen either prior or after business hours will incur an additional fee. Any emergency patient who has been referred by either a hospital or a referring doctor who is seen during holidays and or on weekend days will also incur an additional fee.

WALKIN OR EMERGENCY PATIENTS: These are patients who have not been given an appointment in advance but have a medical or dental condition deemed urgent by either a referring physician or hospital. These patients will be seen in the order of condition necessity. These patients will incur an additional fee.

ORAL BIOPSY PATIENTS: Please be aware that our office is not affiliated with any medical insurance carriers. Payment in full for your biopsy evaluation or procedure is due on the day of your visit. Our office reserves the right to third party billing for pathology services. We are not responsible for laboratory fees incurred or insurance affiliation of the laboratory used.

DENTAL CONE BEAM CT SCAN: Please note most scans completed are for dental purposes only and are not a covered benefit. These scans will not be eligible for medical insurance benefits. Payment in full is due at the time of your study.

MEDICAL CONE BEAM SCAN: Patients who require a scan for a medical diagnosis should provide the front office staff with a valid medical insurance card. Medical diagnosis can only be determined by the doctors during the time of your evaluation. Should preauthorization be required, the scan will be rescheduled for a later date. Please note your benefits will be reduced due to our nonparticipating insurance status.

PAYMENT DUE IN FULL AT THE TIME OF SERVICE:
Payment obligations are due in full at the time of service. If you are experiencing circumstances beyond your control, please call our practice and we will make special arrangements. If not, the following is our office policy:

1. If payment isn't made in full within 30 days, monthly interest will be accrued each month until the balance is paid in full.
2. After 120 days, if the balance is not paid in full and an agreement has not been made with our practice, the account will be placed in collection and the patient will be responsible for any fees and costs associated with collecting the bill.

Thank you for understanding our financial policy. Please do not hesitate to contact our staff so that we can make every effort possible to clarify any misunderstandings or to answer any questions you might have.

HIPAA NOTICE OF PRIVACY: Effective April 14, 2003, Dr. Pacelli and staff have been fully trained in accordance with HIPAA guidelines. Please be aware that your patient records and treatment are confidential. This information can only be discussed with yourself or a parent if you are a minor and your referring physician (s).

Should you wish that this information be discussed with anyone else, such as a conservator, power of attorney, legal guardian, or a medical proxy, please list their name on the provided line below:

_____

RELATIONSHIP: _____

I hereby have read and understand all the policies set forth by New Canaan Oral and Maxillofacial Surgery, P.C. including the financial policy outlined above. I guarantee payment of all charges incurred for the account of the below patient and agree to pay any attorney's fees, court costs, and related collection fees incurred. I certify that I read, comprehend, and speak the English language. Please sign and date below. Our office thanks you and looks forward to caring for your oral surgery needs.

SIGNED: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____