

Financial and Insurance Agreement

I hereby accept full financial responsibility for the prompt payment of all medical and/or dental services rendered to _____ (name of patient), by Southern Louisiana Oral and Maxillofacial Surgery, Dr. Walter Jung, DDS. I agree to pay promptly in full any additional fees, costs, and/or expenses, including, but not limited to, investigative costs, attorneys fees, court costs, filing fees, interest, penalties and all other costs and expenses actually incurred by or on behalf of Southern Louisiana Oral and Maxillofacial Surgery, Dr. Walter Jung, DDS in the event service of an attorney and/or collection agency are utilized for the purpose of collecting any delinquent balance due on this account. I also understand that, as a courtesy to me, Southern Louisiana Oral and Maxillofacial Surgery, Dr. Walter Jung, DDS, will assist me in processing my insurance claim. However, in the event forty (40) days have passed from the date of submission of my claim to my insurance carrier and the balance remains unpaid, I agree to immediately pay the balance due on this account to Southern Louisiana Oral and Maxillofacial Surgery, Dr. Walter Jung, DDS. I agree to pay interest at the rate of one and one half (1 ½ %) percent per month on this account if it remains unpaid for forty (40) days from the date the insurance was submitted to my insurance carrier.

Due to overwhelming claims (over 35%) being lost by insurance companies, we are now sending all claims certified mail. This allows us to track when your insurance company receives your claim. Due to the cost of certified mail, we will only process one claim to your insurance company. If they do not receive or lose this claim, it will be the responsibility of the patient to process the claim. I understand and accept the procedures and/or services not covered by my insurance carrier will not be billed to them, and by signing this, I also agree I am fully responsible for those charges.

By signing this agreement, I understand that lumping, bundling, and/or changing of CDT-3/CPT diagnostic codes is a method used by insurance carriers to reduce reimbursement. This practice of changing the diagnosis is not accepted by the American Dental Association nor Southern Louisiana Oral and Maxillofacial and will not be allowed to reduce your financial obligations for services.

By signing this statement I agree to the assignment of benefits to Dr. Walter Jung for any services performed in the office or in a hospital.

There will be a \$50.00 service fee added for all NSF checks.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of any original.

Name: _____ Date: _____
Signature

Please Print

Co-Signer Agreement

(You must have a co signer if you are covered under your parent/guardian's insurance policy)

As co-signer for, _____, I personally guarantee payment of all medical and dental expenses incurred by this patient at Southern Louisiana Maxillofacial Surgery for products and services rendered by Dr. Walter Jung. I personally guarantee payment in full of any additional collection fees, cost and expenses including, but not limited to, investigative costs, attorneys fees, court costs, filing fees, interest, penalties and all other costs and expenses actually incurred by or on behalf of Southern Louisiana Oral and Maxillofacial Surgery, Dr. Walter Jung, in the event service of an attorney and/or collection agency are utilized for the purpose of collecting any delinquent balance due on this account.

Name: _____ Date: _____