FINANCIAL AND INSURANCE AGREEMENT

I hereby accept full financial responsibility for the prompt payment of all medical and/or dental services rendered to
____, by **Southern Louisiana Oral & Maxilliofacial Surgery**,
(Name of Patient)

I understand, as a courtesy to me, **Southern Louisiana Oral & Maxilliofacial Surgery**, Dr. Walter J. Jung, D.D.S., will assist me in processing my insurance claim. I understand this office files **ONLY ONE** insurance company, and that is the **primary insurance carrier**.

This notice is to acknowledge that our office does not file secondary insurance claims. As a courtesy to our patients we are more than happy to assist you in the filing of your secondary insurance. However, Dr. Jung and staff will not be responsible for any follow up and collections of your secondary insurance. Furthermore, as a contracted provider we are **required to discount primary insurance only**. We will **not apply any discount from your secondary insurance**, which we assisted you in filing or you have filed on your own.

In the event forty (40) days have passed from the date of submission of claims to my insurance carrier and the balance remains unpaid, I agree to immediately pay the balance due on this account to **Southern Louisiana Oral & Maxilliofacial Surgery,** Dr. Walter J. Jung, D.D.S.

I am aware that interest at the rate of one (1 %) percent per month will be applied if my account remains unpaid for **sixty (60) days** from the date the insurance was submitted to my insurance carrier. 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 agree to pay promptly in full any additional fees, costs, and/or expenses, including, but not limited to, investigative costs, attorney's fees, court costs, filing fee's, interest, penalties and all other costs and expenses actually incurred by or on behalf of **Southern Louisiana Oral & Maxilliofacial Surgery**, Dr. Walter J. Jung, D.D.S.

The use of any **financial institute** to fund any dental services will require a **10% administrative/processing fee.** (i.e. Chase, Capital One, etc.) By signing this agreement I understand this amount will not be applied toward any dental treatment and is only charged if the financial institute approves my application.

Biopsy patients: Please be advised the lab is separate from our office and a separate bill will be sent to you for lab services provided.

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. The American Dental Association does not accept this practice of changing the treatment and/or diagnosis codes nor will **Southern Louisiana Oral & Maxillofacial Surgery** allowed this to reduce your financial obligations for services.

By signing this statement I agree to the assignment of benefits to doctor Walter J. 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.

Name: ____ **Date**: ______________________
(Signature)

____
(Please Print)

Co-Signer Agreement

As co-signer for, ___________________________, I personally guarantee payment of all medical and dental expenses incurred by this patient at **Southern Louisiana Oral & Maxilliofacial Surgery** for products and services rendered by Dr. Walter J. Jung. I personally guarantee payment in full of any additional collection fees, costs and expenses including, but not limited to, attorney's fees, court costs, filing fees, investigative expenses, penalties and all other fees **Southern Louisiana Oral & Maxilliofacial Surgery**, Dr. Walter J. Jung, D.D.S., may incur in the event that the services of any attorney and/or collection agency are utilized for the purpose of collecting this account.

Name: ____ **Date**: ______________________
(Signature)