WESTCHESTER ORAL & MAXILLOFACIAL ASSOCIATES, PLLC

Thank you for choosing Westchester Oral & Maxillofacial Associates as your dental provider. Please be assured that your care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our financial policy is important to our professional relationship with you. Please feel free to ask any questions you may have.

Co-Payments

We are required to collect your copayment at the time of visit. There will be a $15 surcharge applied to your balance if your co-pay is not paid at time of visit. WOMA accepts cash, check, and credit cards.

Insurance

We will require a copy of your dental and medical insurance card for our files. Please inform of us of any change in your insurance coverage. Please remember, insurance is never a guarantee of payment.

Participating plans- WOMA participates with most insurance plans. In order to properly bill your insurance company we require all necessary insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-payments, deductibles, or non-covered services not paid by your insurance.

Non-Participating Plans

If we are out of network for your insurance, payment is due at time of service.

Self-Pay

Payment is expected at time of visit. We do offer payment plans in office if the visit exceeds $1,000.

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Cancellation/No Show Policy

A $75 will be applied to your balance if you do not arrive for an appointment and do not cancel prior to the late cancel period.

Patient Financial Responsibility

I acknowledge full responsibility for services rendered by Westchester Oral & Maxillofacial Associates, PLLC. I understand that I am responsible for the prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to the applicable co-pay charge.

Acknowledgement & Agreement

- ❑ **I have read and understand the above. Any questions I had about this form have been answered.**

Name of Patient_____**Date**_____

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Signature of Patient or Parent