ANACAPA ORAL SURGERY DENTAL IMPLANT CENTER

Marwood Stout, D.D.S., Inc.
771 E. Daily Drive, Suite 215 • Camarillo, California • (805) 389-9500
1701 Solar Drive, Suite 291• Oxnard, California • (805) 981-8144

Pre-Surgical Instructions, Financial Policy, and Deposit Agreement 12/23

Patient Name: _____

Appointment Date: _____ Time: _____ Location: ❒ Camarillo ❒ Oxnard

Planned Treatment: _____ Anesthesia: ❒ Local ❒ Sedation

Pre-Operative Instructions: In order to provide you with the very best care, please read and observe the following:

1. On the day of surgery, **do not consume any food, drink, or water for at least 6 hours prior to your surgery,** if sedation/general anesthesia is planned**.** The exception is to take your medications with just a sip of water.
2. Unless Dr. Stout has specified otherwise (blood thinners and diabetic medications are usually withheld for your surgery). **Take all your prescribed medications at your normal schedule, even a morning dose** Avoid alcohol and smoking prior to surgery. Notify Dr. Stout if there has been a change in your health or medications.
3. Wear loose-fitting clothing with short sleeves. Do not put lotion on arms, hands, or face. Leave jewelry and contact lenses at home. Remove all facial and oral piercings. Brush your teeth thoroughly prior to your appointment.
4. A responsible adult must accompany you to your appointment, register with you at check-in, **be prepared to remain here during your procedure**, drive you home, and assist in your recuperation that day.

Insurance: We are happy to assist in submitting your claim and get as much benefit for you as possible. Since we can only obtain an *estimate* of your benefits, **your final out-of-pocket expense is not certain, and the amount due and paid at surgery does not settle your bill.** Insurance frequently disappoints. Denials are common in spite of appropriate need and even written pre-authorization, particularly when the annual maximum benefit has been exceeded. Since we are not an agent of your insurance carrier, we cannot compel them to authorize treatment or send a desired payment. Our quoted fees shall always prevail over an insurance carrier's disagreement with our billing or procedure coding, especially in package fee treatments with partial insurance coverage. If your insurance has not paid within 45 days, any unpaid balance is due for payment and begins to accrue interest at 1.5% per month, even if your claim is still pending. Accounts sent to collections are subject to substantial fees. Treatment fee estimates are valid for 6 months.

Payments and Financial Arrangements: We accept cash, credit cards (Visa MC, or Discover), and debit cards. <u>We do not accept any checks, either personal or cashier's checks.</u> If paying by cash, your out of pocket costs will be lower. If outside financing is needed, this must be arranged right away so that approval can be obtained before the missed appointment fee window. It is not certain approval for outside credit can be obtained on the day of surgery. Subprime financing is subject to an additional charge of 5%.

Appointments: In setting your appointment, we set aside an operating suite, instruments, sterile supplies, and time for doctors and team members to care for you; so it is very important to not miss your appointment. **You will be charged a substantial fee, at least 25% of your treatment cost, if you miss your appointment or cancel or reschedule less than 3 business days prior**, or if you arrive for your appointment exceptionally late, without an empty stomach, unprepared to pay for treatment, or for any other reason do not proceed with your appointed treatment. Appointments can be rescheduled by speaking to one of our receptionists, but not by phone message or e-mail.

Cash treatments that will <u>not</u> be submitted to insurance:
❑ Tooth Socket/Jawbone ridge preservation
❑ Blood/ stem cell concentrate therapy (PRF)
❑ Panoramic to CT imaging upgrade cost
_____
_____

Total treatment cost: $_____
Estimated insurance benefits $_____
Non-refundable deposit $_____

Due at check-in on day of surgery:
Credit, debit, or CareCredit $_____
Cash $_____

_____ **I am personally responsible for all professional fees irrespective of any insurance benefits/coverage.**
_____ **No insurance benefits or payments have been promised. Estimated benefits/payments are uncertain.**
_____ **A balance may be due after my insurance payment, partial payment, or denial.**
_____ **The Guardian/Responsible Party, if signed below, agrees to assume all financial responsibility**.
_____ **I have received a copy of my informed consent language for the procedure(s) discussed.**

We look forward to the opportunity to care for you and wish you all the best for a successful surgery and a smooth recovery. Please call us if you have any questions regarding your upcoming treatment. Your signature below does not obligate you to proceed with treatment, but is an acknowledgment you understand and agree to the terms above.

_____ _____ _____
Patient Signature Guardian/Responsible Party Signature (if applicable) Date