OMS SPECIALSIST, PLLC
FINANCIAL POLICY

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- **Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered, is due when services are rendered.**
- **As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.**

We do not accept assignment of benefits for secondary insurance, however, we will provide a claim form for you so that you may file and be reimbursed by your company.

Payment may be made by any of the following methods. Please indicate your method of payment below.

CASH _____ CHECK_____ Master Card ~ Visa_____

Information is available upon request for third party financing through the following:

Dental Fee

- **I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.**
- **I agree to pay any and all unpaid balance on my account.**
- **I authorize all insurance benefits paid directly to OMS Specialists.**
- **If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to OMS or make payment immediately to OMS Specialists.**
- **I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.**
- **A finance charge of 1.5% will begin to accrue after 60 days from the date of service on the unpaid balance of my account even though insurance may be pending.**
- **A fee of $29.00 will be incurred for each returned check.**
- **I agree to pay collection costs, attorney's fees, court costs, and interest from the date of treatment if this account is assigned to collection status.**
- **I have read, understand, and agree to the above terms.**
- **I authorize this office to discuss my account with a spouse or parent/step parent (if patient is not a minor but using parent or step parent insurance).**

______________________________ ____________________

Signature of Responsible Party **Date**

OMS SPECIALIST,PLLC
366 South Lowry St.
Smyrna, TN 37167
615 220 5525

AGREEMENT

I, ______________________________________, agree to be financially responsible for any and all unpaid balance including finance charges incurred (if applicable) on the account of ____________________________________ for all services rendered. Failure to pay this account in full may result in this account being assigned to collection status, collection agency, or attorney for collection and/or suit in which case I assume responsibility and agree to pay for collection fees, court cost, and attorney fees and interest from the date of treatment. This agreement will be in effect until I give written notice of cancellation.

______________________________	______________________
RESPONSIBLE PARTY	**DATE**