John E. Truitt, D.D.S, P.C.

Oral & Maxillofacial Surgery

(804) 789-0230

Office Financial Policy

Co-payment and deductibles are to be paid in full at the time of treatment. We will **estimate** amount you owe based on the information we receive from your insurance company. **Your insurance company determines the allowable charges for your procedure. Your insurance company determines how much they will pay and what your portion is. We cannot guarantee how much your insurance company will pay.**

If there is no insurance coverage or the treatment is not a covered service, then payment is due in full at the time of treatment. Financing is available and does require qualification and three business days to process.

If this account is referred to an attorney for collection, there the undersigned person(s) promise and agree to pay all collection costs including attorney fees of 33 1/3%of the principal amount due and owing when turned over for collection and do further agree to pay interest at a rate of 1 ½% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer to provide verification of my said employment to this office, or their attorney.

The returned check fee is $35.00.

We accept VISA, MASTERCARD , DISCOVER & AMERICAN EXPRESS. All charges must be signed by the cardholder in PERSON. We also offer a 6 month, interest free payment plan through Care Credit.

I hereby authorize payment from my insurance company directly to John E. Truitt, D.D.S. **I understand I am fully responsible for my bill should any portion not be paid by my insurance company.**
_____(initial)

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Signature of Patient (or parent if under 18)

_____
(Signature of Responsible Party)

_____
Date