

HASSAN ORAL SURGERY

HASHIM J. HASSAN, D.M.D., P.C.

Financial Policy

Payment for services rendered is due in full at the time of service. We accept cash, check, debit cards, & credit cards (Visa, Mastercard, and American Express).

To assist our patients, we gladly accept CareCredit and Springstone Patient Financing. We will provide you with the application or you may go online via the internet to apply.

FOR PATIENTS WITH INSURANCE: As a courtesy to our patients, our office will verify your insurance benefits, file your claim, and collect your co-insurance and deductibles (what your insurance will not pay). When we verify your insurance coverage the insurance company does not tell us the exact payment that they will make on your behalf, therefore, it is only an **estimate** until the actual claim is processed. **Please understand that the insurance contract is between you and your insurance company, therefore, it is your responsibility for any unpaid balance.**

I understand that if my account becomes delinquent it will be placed with Prim and Mendheim LLC. I also agree and consent to the following terms regarding any outstanding balance that I owe:

- (1) I will incur interest on the balance due at the rate of 1 & ½ percent per month (18% PER ANNUM);
- (2) I will be responsible for reasonable collection costs and attorney's fees in and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and
- (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding any outstanding balance and/or debt that I owe, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive are rights to claim exemption.

I affirmatively consent to and agree not to claim any and all personal property, homestead, and/or wage exemptions, in particular that certain wage exemption contained in Article X of the State of Alabama Constitution of 1901, that I may be entitled to, whether the said exemption be statutory and/or constitutional in nature, and waive any and all defenses thereto. I further agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida, I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time my balance has not been paid as I have agreed herein that my credit history will be investigated and thoroughly reviewed. By signing below, I consent to the foregoing terms and affirmatively

acknowledge that I have read, or have been provided adequate time to read, the foregoing before signing below.

Patient's Name

date

Responsible party signature

date

If you have insurance, please sign the following giving the insurance company permission to pay directly to our office:

I request payment of authorized insurance benefits to be made on my behalf to HASHIM J. HASSAN, D.M.D., P.C. for services rendered me by the listed facility and/ or physician.

PATIENT'S/ LEGAL GUARDIAN SIGNATURE

DATE

HIPPA

I acknowledge that Hashim J. Hassan, D.M.D., P.C. will not give out any health information to anyone other than my insurance company, my referred general dentist, and/ or the persons listed below. I have been given the opportunity to read and ask questions about the Health Information Privacy Practices of this office.

Signature of Patient, Parent, or Guardian _____

Date _____

This office has permission to release and discuss my health information with the following people:

Name

relationship

Name

relationship