Richard C. Fugler, D.D.S., M.D.

PATIENT FINANCIAL INFORMATION & CANCELLATION POLICY

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are performed.

We accept cash, check, all major credit cards and Care Credit.

If payment is made in full by either cash or check, a discount may be applied. **No discount will be given if an insurance assignment is accepted, if using a major credit card, or if you are using a healthcare finance option (such as Care Credit) for payment**.
The discount applies to surgical procedures only and excludes consultations, exams, x-rays, and All-on-4 procedures.

We are happy to assist you in processing your insurance claims. It is important that you provide our office with all of the necessary insurance cards and information required to process these claims. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. ***Please read and sign our Medical and Dental Insurance Policy.***

If your insurance carrier pays in excess of what is owed, our office will reimburse you up to the maximum amount you have paid within two weeks of receiving the payment. However, if your insurance carrier pays less than what was estimated, you will receive a bill showing the balance due and asked to pay this upon receipt. All payments are to be paid to Lake Jackson OMS, PLLC, and sent to 103 Abner Jackson Pkwy, Lake Jackson, Texas 77566.

I have read the above information and understand that payment is due at the time services are rendered, that the contract with the insurance carrier is between the insurance carrier and insured and that all charges for services are my responsibility and are due and payable by me.

I further understand that if I default on the obligation that I will pay a $25.00 service charge plus costs of collection and any attorney's fees and court costs.

Responsible Party: _____ **Date:** _____

CANCELLATION POLICY

Canceling or re-scheduling a **surgery appointment** with less than **72 hours**, or **three full business days' notice** will require pre-payment of the full amount prior to having the appointment re-scheduled.

Canceling or re-scheduling a **consultation appointment** with less than **24 hours**, or **one full business** day notice or failure to show up for the appointment will require pre-payment of a $100 non-refundable fee prior to having the appointment rescheduled.

I have read the cancellation policy and understand that if I cancel my appointment within the cancellation period as stated above, I am responsible for a pre-payment or non-refundable fee before my appointment can be rescheduled.

Responsible Party: _____ **Date:** _____