Desert Valley
ORAL SURGERY

Financial Policy

Thank you for choosing us as your Oral Surgeon. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Patient Information Form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS, CHECK, CARE CREDIT & SUNBIT.

Beginning 1/1/25: Mastercard, Visa, Discover and American Express credit cards will be charged a 2% convenience fee that will be added to your payment. This fee does not apply to cash, check, HSA/FSA cards, or debit cards

REGARDING INSURANCE:

We do accept the assignment of insurance benefits after confirmation of eligibility.

However, we require your estimated portion of the bill to be paid along with your deductible at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information and fill out the necessary information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Even though we accept assignment of benefits, we want you to know that if your insurance has not paid your account in full within 60 days, the balance of your account will automatically be your responsibility.

Please be aware, some and perhaps all the services provided may be “non-covered” services excluded from your insurance contract.

As a courtesy, we provide an estimate based on what your insurance company tells us over the phone on the day of service. Estimates are not a guarantee of payment.

Thank you for understanding our Financial policy. Please let us know if you have any questions or concerns.

By signing this form, you have read the financial Policy (above) and understand and agree to this Financial Policy.

Print Patient Name: _____ Date: _____

Patient or Guardian/Responsible Party Signature: _____