SADDLE ROCK INSTITUTE

RYAN DOBBS, MD, DDS
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Notice of Billing Practices
Saddle Rock Institute
Effective: November 1, 2020

Thank you for choosing Saddle Rock Institute as your health care provider for your oral and facial reconstructive surgical needs. We deliver the finest care at the most reasonable cost to our patients; therefore, payment is due at the time service is rendered unless other arrangements have been made in advance. The fees in our office are based on the care, skill, time, and judgment necessary to help treat your condition. The fee(s) for your treatment will be discussed and a detailed estimate shall be provided to you prior to any treatment.

The following is a detailed description of our financial policy:

- We reserve the right to collect payment before services are rendered
- We accept cash, check, Visa, MasterCard, Discover and American Express
- We will be happy to assist you with applying for financing, should you so desire, with companies who specialize in healthcare financing for patient treatments
- **Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage**
    - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
- Fees for non-covered services, deductibles, and co-payments are due at the time of treatment
    - Because insurance policies vary greatly, we can only estimate your coverage and cannot guarantee coverage due to the complexities of insurance contracts
    - Your estimated portion must be paid at the time of service
    - As assistance to our patients, we will bill insurance companies for services rendered and allow them 45 days to remit payment
    - If your insurance company does not pay your claim within 90 days, you are expected to pay the entire balance due
    - If the balance is not paid after 120 days, interest will be automatically charged at a rate of 20% APR
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak to us if you encounter such problems, so that we may assist you in the management of your account.
- Please bring your medical and dental insurance information with you to the consultation visit so we can expedite reimbursement. We will work hand in hand with you to maximize your insurance reimbursement for covered procedures. Please know your dental and medical insurance benefits. The surgeons will decide based on the consultation whether the treatment will be billed to your medical or dental insurance. If you do not have medical insurance and the oral and maxillofacial surgeons deem the treatment is medical, you will be required to pay out-of-pocket. If you do not have dental insurance and the oral and maxillofacial surgeons deem the treatment is dental, you will be required to pay out-of-pocket.

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- If a check is written and at the time of deposit it comes back as insufficient funds you have 10 days from the date of service to present payment in a different form (cash, credit, or debit). All checks that are returned as insufficient funds will incur an additional $30.00 fee. If after 10 days, you have not settled the account with a new form of payment you will be sent a certified letter according to the Bad Check Restitution Program with the Arapahoe County District Attorneys office. That letter will state you have 15 days from the date of the letter to settle your account. If you fail to settle your account within those 15 days, you will be turned over to the District Attorney for administration of a check warrant.

We appreciate your trust and the opportunity to serve you. Our patients are very important to us. If you have questions or need assistance regarding your account, please contact us at 720.826.8900. Our courteous staff is always available to help answer them or provide further clarification.

I have read the above conditions of payment and agree to their content. I grant my permission to you and your assignee, to telephone me at home or at my place of work to discuss matters regarding this form. I authorize and request my insurance company to pay directly to Saddle Rock Institute otherwise payable to me. I agree to be responsible for payment of all services rendered on behalf of my dependents.

_____ _____

Patient/Parent/Guardian – Printed name Date

_____ _____

Patient/Parent/Guardian – Signature Date