



**DIXIE ORAL MAXILLOFACIAL
& IMPLANT SURGERY**

John H. Mizukawa, D.D.S. Wayne H. Dudley, D.D.S.
BOARD CERTIFIED, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

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415 N. Main, Ste. 204
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FINANCIAL AGREEMENT

We are pleased to have you as our patient and appreciate the confidence you have shown in our office. It is our goal to offer exceptional professional care and customer service.

For your benefit, upon completion of each visit, **we offer a 5% courtesy to all patrons who pay in full with cash or check.** An estimate of the charge for any procedure or surgery you may desire will be given prior to service upon request.

Please remember the insurance contract is between the insured's employer and the insurance company. You are responsible for the cost of services rendered on your behalf. As a courtesy to you, we will assist you in submitting your claim to your insurance company. We require a deposit payment and the following information: Name of Insured, Date of Birth, Insured's Employer and Group Number, Insured's Social Security Number and ID Number, and Name, Address and Phone Number of Insurance Company.

Dental insurance provides coverage for a limited number of basic services. Some companies pay fixed allowances for certain procedures, others pay a percentage of their "allowable" charge. **It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your insurance company.**

Additionally, as a courtesy to you, we offer financing through **Citi Health Card and CareCredit, including a 6-month to 18-month interest-free option** if you qualify and sign-up on the date of service. This also applies to any balance after insurance pays if application is made the date of service. Please ask our customer service personnel for more information if you are interested in this option.

There is a monthly service charge of 1.75% (annual interest rate of 21%) of the unpaid balance for accounts over 90 days.

In the event this account goes to Collection, I understand that I am responsible to pay all costs and reasonable attorney fees required to collect monies owed by me that may be assessed to Dixie Oral, Maxillofacial & Implant Surgery by any agency retained to pursue this matter. These charges or commissions may add up to 33.3% of the outstanding amount to your account balance.

I have read the above information and agree to the terms outlined herein.

Signature (must be over 18 years of age)

Date