



PORTER, MARTIN, SALMAN, PA
Oral & Maxillofacial Surgery

OFFICE AND FINANCIAL POLICIES

Please read our office and financial policies completely. If you have any questions or concerns, please direct them to our Office Manager at 856-596-9099.

I understand that I will be asked to provide my insurance card and picture ID at each visit.

I understand that because every insurance policy is different, it is **my responsibility** to understand the rules and terms of my insurance, not the responsibility of the staff at Porter, Martin, Salman. Any insurance benefits that are obtained and quoted are provided to you as a courtesy and are just **an estimate and not a guarantee of payment**. I will be provided with all the necessary information that I will need to contact my insurance carrier prior to any procedures.

I understand that a diagnosis code and/or a procedure code cannot be changed for the purpose of securing reimbursement from insurance carriers.

I understand that I am expected to pay all co-payments and deposits **at the time of service**. I will be asked to reschedule my appointment if I cannot pay at this time.

I understand that if my insurance requires a referral to see a specialist it is **my responsibility** to contact my PCP office to obtain one. If no referral is on file the day of my visit I will need to reschedule my appointment.

I understand that I am expected to pay any and all balances within 60 days unless other payment arrangements have been made with the office.

I understand that any unpaid balances on my account will be referred to an outside collection agency or small claims court who will report to the credit bureau and/or resort to further legal action.

I understand that all Legal and Collections fees incurred by Porter, Martin, Salman in relations to recovery of all outstanding balances will be the patient's responsibility.

I understand that future services **will not be scheduled** if any past due balances are not paid in full or if a payment plan is not in place with the office.

Patient Name

Patient Signature

Date