SA Stewart & Arango
ORAL, FACIAL & IMPLANT SURGERY

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CREDIT CARD / PAYMENT AUTHORIZATION

It is not possible for our office to know the exact details of every insurance plan. Non-covered services, deductible amount, remaining annual maximum benefit, claims in process from other offices, and co-insurance responsibility are all variable. The exact patient responsibility amount is unknown at the time of your appointment(s).

We are happy to provide an estimate for your procedure(s) based on the information we receive from your insurance company. We are also happy to file insurance claims for you as a courtesy.

All insurance companies have the same rule when we call to verify your coverage details: **any information provided by the insurance company via phone conversation or a faxed document does not guarantee coverage or payment from the insurance company.**

Exact patient responsibility is unknown until the insurance company processed the claim.

If you would like our office to file and maintain your insurance claims, we ask for an updated credit card to keep on file in order to charge any remaining patient out-of-pocket responsibility, up to $500, after the insurance company has paid their portion. Should your remaining responsibility exceed $500, we will notify you prior to charging your credit card. In order to cancel this authorization, please send written authorization to Stewart & Arango Oral Surgery at the address listed above.

If you prefer to pay your balance in full and be reimbursed by your insurance company directly, we will not need this information.

Name of patient: _____

Name on card: _____

Card number: _____

Expiration date: _____ CVV: _____ Zip code: _____

Signature of card holder: _____

Date: _____

Relationship to patient: self parent legal guardian spouse partner child
(please choose one)