Financial Policies and Insurance Information

The financial obligations for treatment rendered are your responsibility.
At Athens Oral Surgery Center, we participate with several insurances, including:

Medical: Athens Area Health Plan Select, Blue Cross Blue Shield (PPO, POS, HMO)

Dental: Athens Area Health Plan Select, MetLife, Delta Dental, Cigna, Ameritas, Health Plan Services Corp., Standard Insurance Company, Reliance Standard Life, Principal.

For those plans with which we do not participate, we will gladly submit claims on your behalf.
Insurance plans and coverage vary considerably. **We strongly suggest you investigate your coverage specifics prior to undergoing any treatment.**

At Athens Oral Surgery Center, we require a deposit at the time of treatment.

-If one of the above insurances, the amount of your copay
-40% if insurance other than above
-50% if no insurance coverage

A late fee of 20% of the remaining balance will be added to any account with no payment for 90 days.

I have read, fully understand, and agree to the above financial policies, and also agree that I am fully responsible for the entire cost of all services rendered by Athens Oral Surgery Center, including any balance remaining after my insurance has met its obligations.

X_____ _____ _____
Signature Patient/Resp. Party Printed Name Date

Address_____ Phone_____
Alt. Phone_____
Employer & Address_____ Work Phone_____

Primary Insurance_____
Ins. Address_____
_____
Policy Holder_____
Relationship to Patient _____
SSN:_____ DOB:_____
Policy # _____
Group# _____
Employer_____
( ) Medical ( )Dental

Secondary Insurance_____
Ins. Address_____
_____
Policy Holder_____
Relationship to Patient_____
SSN:_____ DOB:_____
Policy # _____
Group# _____
Employer_____
( ) Medical ( )Dental

Is this condition due to an accident or worker's compensation injury?___ If yes, date of accident?_____

I hereby authorize and request my insurance company to pay directly to Dr. Jonathan Tomlinson the amounts due on my claim for services rendered to me or my dependent.

X_____ _____ _____
Signature Patient/Resp. Party Printed Name Date