California Center For Craniomandibular Disorders

The Dental Practice Of Mark Abramson, D.M.D., Inc.

Dental Sleep Medicine Temporomandibular Disorders Craniofacial Pain Management

STANDARD OFFICE POLICY

Welcome to our practice. We are pleased that you have chosen us for your care and will strive to help you with the best of our knowledge and expertise. Please read the following carefully and sign at bottom.

Broken Appointments
We require 24 hour phone notification if you are unable to keep your scheduled appointment. If we do not receive this notice, your account will be subject to a charge based upon the standard overhead rate for the length of time you reserved with your doctor. Insurance will not cover this charge, so it will have to be paid out of pocket.

Payment of Account
It is our policy to receive full payment for your initial examination, x-rays, follow-up visits, appliances, or emergency visits at the time the service is rendered. For your convenience we accept VISA and Mastercard as well as cash or checks. We understand that some patients have special needs. If the above is unsuitable, you must make arrangements and discuss with the front desk manager before treatment is rendered.

TMJ or Sleep Apnea-Insurance Information
Since we do not file insurance claims for you, you must file your own claims for reimbursement from your insurance company. Dental insurance will not usually cover TMJ or Sleep Apnea therapy. These claims should be submitted to your medical insurance carrier. The itemized statement we provide should be attached to your medical claim form when you submit a claim. Make sure you fill in employee section thoroughly. It is not necessary for physician's statement to be filled in.

Orthodontic or Other Dental Procedures-Insurance Information
As a courtesy to you, we will bill your insurance company for dental or orthodontic services rendered. In order to do so, you must supply us with complete information regarding your insurance and employer, including the proper insurance forms, filled in and signed by the employee. We expect payment in fall at the time services are rendered unless special arrangements are made with the front desk manager. We do not "accept assignment" meaning that the insurance will pay you and not us. In the event that the insurance company does pay us and if your account balance is -0-, we will endorse the check over to you and mail to you. Problems with insurance coverage and payment are the sole responsibility of the patient as the contractee with his/her employer and the insurance company.

Kaiser Patients
We are contracted with Kaiser and will handle the billing of your account directly with them. Please present your Kaiser card upon check-in and be prepared to pay your co-pay. Please note that different programs with Kaiser cover different amounts and we will inform you of this upon your first visit. All Kaiser patients must be pre-authorized for treatment.

PAMF or TriCareATriWest
If you are insured by either of the above and nave prior authorization, we will process these claims as we are contracted with them. By signing below you are authorizing payment directly to us for the services provided. You are expected to pay co-payments at the time of the visit.

Delinquent Accounts
Any account which has not had a payment for 30 days is considered delinquent and will have a late charge of 1.5% per month added. If an account has not had a payment for over 60 days, it may be subject to outside collection action or turned over to our attorney or Small Claims Court. If this account is assigned to an attorney, the prevailing party shall be entitled to reasonable attorney's fee and cost of collection.

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of outcome, insurance coverage or expected case settlements.

I have read, understand and agree to the above:

Signature of Patient or Responsible Party___________________________________Date____________

Diplomate, American Board of Dental Sleep Medicine
Diplomats, American Board of Orofacial Pain
Diplomate, American Academy of Pain Management
Fellow, Academy of Craniofacial Pain

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