TMJ & OROFACIAL PAIN TREATMENT CENTERS OF WISCONSIN
Financial Policy

Patient's Name: _____, Date of Birth: _____

Updated 1/2017

Billing & Financial Information:

A copy of your insurance card is required at each visit. If you do not have your insurance card(s) you may be asked to pay for all services performed.

I understand that the TMJ & Orofacial Pain Treatment Centers of Wisconsin ("TMJ Centers")/LMG Inc., will submit my charges to my insurance company for services, provided they have complete insurance information, except for device repairs which are at my own expense. It is my responsibility to notify the TMJ Centers of any changes in my healthcare coverage. I understand and have been notified in advance that Drs. Mackman, McDaniel, Tache, Mier and the TMJ & Orofacial Pain Treatment Centers are NOT Medicaid providers. I agree to accept responsibility for payment for these non-covered services. I understand that I am financially responsible to the TMJ Centers for any charges not covered by my healthcare benefits, including all co-pays, co-insurance and deductibles. I am responsible for the entire bill or balance of the bill as determined by the TMJ Centers and/or my healthcare insurer if the submitted claims or any part of them are denied for payment or if the submitted claim(s) are processed as not medically necessary by my healthcare insurer.

I understand that my health insurance company does not guarantee benefits. Services rendered by Affiliated Health, Pain Rehabilitation Associates, Radiology and Dental Imaging Centers, and/or Physical Therapy are billed separately and are not included in your TMJ Centers/LMG, Inc. billing. For your convenience, however, the TMJ Centers reserves the right to apply patient payments between corporations (LMG, Inc./Affiliated Health of Wisconsin, Ltd.) unless otherwise requested in writing from you.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for the missed appointments at the rate of a normal office visit. This is billed directly to you, the patient. Insurance companies do not cover missed appointments.

Return/Repair Policy: All sales are final. I, the undersigned, agree that if I choose not to continue with the fit of the appliance after it has been custom made, I will be personally responsible for a cash payment of $500, which is not billable to my insurance plan. All repairs are subject to a separate charge and are not billable to my insurance plan.

Medical Consent: I, the undersigned, hereby consent to medical care including, but not limited to: examinations, X-rays, medical treatments, administration of medications and appliances, as are, in the judgment of the treating practitioner, medically advisable for the patient identified above. I understand that no guarantee has been made as to the results of the care, treatment and medications of the patient.

I have read and I understand and agree with this financial policy. I guarantee payment of all charges incurred for this account. I understand that the costs and expenses are solely for the proposed treatment and do not include costs that may be incurred for the treatment complications that may arise or other dental care that may be required due to the use of an oral appliance. I further agree that the TMJ & Orofacial Pain Treatment Centers of WI may reschedule my appointment should I refuse to make payment required by this agreement. I further agree to pay any attorney fees, court costs, and related fees incurred should collection efforts be commenced to collect any unpaid portion of my bill. I also understand that benefits discussed in the office are not a guarantee of payment by my insurance company. This authorization is in effect until I choose to revoke it in writing.

_____ _____

Signature of Patient/Parent/Guardian/Personal Representative Signature — Date

****

For Minor Patients Only: Law states the parent / guardian / personal representative or other legal authority seeking or authorizing medical treatment is responsible for paying the bills. If payment for services is to be paid by someone else, then the parent, guardian or personal representative bringing the child for services must pay and have the other party reimburse them.

I, _____hereby authorize and consent to the performance of an examination, procedures and
(Name of Parent/Guardian/Personal Representative/other Legal Authority)

treatments for _____, which the practitioner may deem necessary.
(Patient's Name)

The consent shall remain in effect until I choose to revoke it in writing.

_____ _____

Signature of Parent/Guardian/Personal Representative/other Legal Authority — Date

T-001 SS BW QP

_____

Description of Parent/Guardian/Personal Representative/other Legal Authority