Robert Laski, DMD
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Oral and Maxillofacial Surgery

Valley Oral Surgery

1275 S. Cedar Crest Blvd., Ste. 1A, Allentown, PA 18103
610.437.1727 fax 610.437.4715

1321 N. New St., Bethlehem, PA 18018
610.861.0648 fax 610.974.8966

5666 Interchange Rd., Lehighton, PA 18235
484.629.8300 fax 484.629.8313

1402 W. Broad St., Ste. 101, Quakertown, PA 18951
215.536.8133 fax 215.529.9498

Financial Policy

Valley Oral Surgery participates with many insurance plans and will file your claim for you. Insurance varies significantly from employer to employer and from plan to plan. As a courtesy to our patients, Valley Oral Surgery will contact your insurance company to establish an estimate of benefits, deductible and/or copayments based on the proposed treatment plan. Information given to us by your insurance company is an estimate and does not guarantee coverage or payment.

Please be aware that some procedures may not be covered or considered medically necessary by your insurance carrier. At the time of your consultation, financial arrangements will be openly discussed. Please note financial obligations for the treatment rendered are the patient's responsibility.

Patients with managed care contracts may need to obtain a referral from their primary care physician.

For your convenience, we accept the following methods of payment: Cash, Check, Visa, MasterCard, American Express, Discover and Care Credit.

If you are a patient of record, please advise us promptly of any changes in your address, health status, or insurance information.

Thank you for choosing Valley Oral Surgery.

_____ _____

Signature Date

Valley Oral Surgery Form Completion Policy

Valley Oral Surgery offers completion of forms as an added service to patients. We have the following policy in place as outlined below.

Instructions:

- Pre-payment of $15 per form is required.
- The following forms will be assessed a $15 fee for completion:
    - FMLA
    - Disability/Life Insurance
    - Letter of condition
    - Miscellaneous Patient Requests
- Patient must complete all of their information on the form prior to submitting ot the office.
- Forms must be requested well in advance of when they are needed. We will attempt to complete the forms as quickly as possible but please allow 5-7 business days.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

By signing below I attest that I have read and understood the above. Upon request, I will be provided a copy of this document for my records.

_____

Printed Name of Patient (Patient's Representative if patient is a minor)

_____

Signature of Patient (Patient's Representative if patient is a minor)

_____

Date