

DR. JAMIE W. ODOM
375 E. CENTRAL AVENUE SUITE 361
WINTER HAVEN, FL 33880
863-875-8820

Financial Policy

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policy.

Initial each paragraph

- _____ Payment is due at the time of service unless arrangements have been made in advance. We accept cash, check, Care Credit, Citi Health, Visa, MasterCard, Discover, and American Express.
- _____ I authorize and assign payment of dental benefits to Dr. Jamie W. Odom for services rendered. The assignment will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid and effective.
- _____ There will be a \$40.00 cancellation or "no show" fee for appointments cancelled without 24 hour notice. **** We do not take cancellations by text/ email as this is an automated service that we do not receive in real time. **** For patients scheduled for a surgical and or restorative procedure, a \$150.00 fee, or 10% of the surgical fee, whichever is greater, will be charged. These charges must be paid prior to scheduling any further appointments. This charge will not be billed to insurance.
- _____ We file insurance for companies we are contracted with unless Dr. Odom is not obligated to accept assignment. Your insurance is a method for you to receive reimbursement for the fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowance or percentages based on your contract with them, not with our office. **It is your responsibility to pay the deductible, co-insurance, and any other balance not paid, or not covered, by your insurance at each appointment.** In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. It is your responsibility to monitor your insurance benefits, deductibles, authorizations, effective date and termination dates of coverage. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. We will wait up to sixty (60) days for payment from your insurance company. If the insurance company has not paid within sixty (60) days, we will expect the balance in full from you at that time.
- _____ In the event that any litigation is required to collect sums due from you under this agreement, the prevailing party shall be entitled to recover all reasonable legal costs and expenses, including reasonable attorney's fees, before trial, at trial, and in any appellate proceeding.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THE STATED FINANCIAL POLICIES OF DR. JAMIE W. ODOM AND AGREE TO ABIDE BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Signature: _____ Date: _____

Print Name: _____