ANACAPA ORAL SURGERY DENTAL IMPLANT CENTER

Marwood Stout, D.D.S., Inc.
771 E. Daily Drive, Suite 215 • Camarillo, California • (805) 389-9500
1701 Solar Drive, Suite 291• Oxnard, California • (805) 981-8144

Dental Implant Pre-Surgical Instructions / Financial Policy

Name: _____

Appointment Date:_____ Time:_____ Location: ❒Camarillo ❒Oxnard

Phase ____ /Planned Treatment:_____
☐Local ☐ General Anesthesia

Pre-Operative Instructions: In order to provide you with the very best care, please read and note the following:

1. The night before surgery, take 600 mg of ibuprofen (Motrin or Advil). Do not take this medication if your physician has advised you to avoid non-steroidal medications.
2. On the day of surgery, **do not consume any food, drink, or water for at least 8 hours prior to your surgery,** if sedation/general anesthesia is planned**.** But it is fine to take your medications with just a sip of water. Should you have any removable appliances such as partials, dentures, etc. please bring them the day of surgery. It is possible adjustments may be needed after the implant is placed.
3. **Take all your prescribed medications at your normal schedule, even a morning dose** unless Dr. Stout has specified otherwise (blood thinners and diabetic medications are usually withheld for your surgery). Avoid alcohol and smoking prior to surgery. Notify Dr. Stout if there has been a change in your health or medications.
4. Wear loose-fitting clothing with short sleeves (it helps with the IV). Leave jewelry and contact lenses at home. Remove all piercing jewelry on the face, lips and mouth. Brush your teeth thoroughly just prior to your appointment.
5. A responsible adult must accompany you to your appointment, register with you at check-in, remain here during your procedure, drive you home, and assist in your recuperation that day.

Insurance: We bill insurance as a courtesy, and we are happy to assist you in gathering pretreatment information about insurance coverage and submitting and following up on your claim. But we are not agents of your insurance carrier, and we cannot compel their payment. We can only request coverage information and act upon it in good faith. Thus our estimate of your coverage, payments, and final out-of-pocket expense is never certain. Denials and disappointments can result in spite of verbal approvals or even a written pre-authorization. If your insurance has not paid within 45 days, any unpaid balance is due from you at that time, even if your claim is still pending. Unpaid balances accrue interest at 1.5% per month. Accounts requiring collection actions are subject to substantial fees. Fee estimates are valid for 6 months.

Payments and Financial Arrangements: We accept cash, debit cards and cashier's checks. If paying with credit cards (Visa, Mastercard, Discover), personal checks, or outside financing, fees are slightly higher. A discounted surgery package fee is available if paying with cash, debit, or cashier's checks where insurance is not involved at all. If you agree to a discounted package transaction, then later decide to utilize insurance, your cash discount will be reversed and you will be charged for full and itemized treatment and required to make full copayments.

Appointments: In setting your appointment, we set aside an operating suite, instruments, supplies, and time for doctors and staff team members to care for you; so it is very important to not miss your appointment. **You will be charged a fee of 25% of your treatment plan if you miss your appointment or cancel or reschedule less than one week prior**, or if you arrive for your appointment exceptionally late, without an empty stomach or suitable escort/driver, unprepared to pay for treatment, or for any other reason decide not proceed with your appointed treatment. Appointments can be rescheduled or cancelled by speaking to one of our receptionists, but not by phone message or e-mail.

	Total treatment cost	$_____
	Non-refundable deposit (due at time of scheduling)	$_____
DUE AT SURGERY (Estimated non-covered portion)	Credit card, financing, personal check	$_____
	Cash, debit card, cashier's check	$_____

_____ **I am personally responsible for all professional fees** irrespective of any insurance coverage.
_____ Guardian/ Responsible Party agrees to personally assume financial responsibility if signed below.
_____ Insurance payment is estimated. **We have not implied or promised insurance coverage or payment.**
_____ A balance may be due from you after your insurance payment, non-payment, or denial.

Thank you for the opportunity to care for you. Please call us if you have any questions regarding your upcoming treatment. We wish you all the best for a successful surgery and a smooth recovery. Your signature below is not a commitment to proceed, but is an acknowledgment you understand and agree to the terms above.

_____ _____ _____
Patient Signature Guardian/ Responsible Party Signature Date