ORAL & DENTAL IMPLANT SURGERY

BOARD CERTIFIED ORAL & MAXILLOFACIAL SURGEONS

I hereby authorize all licensed Oral Surgeons, to release all financial, medical, and other information to my insurance company or my representative, including any attorney of record, with respect to all illnesses or accidents, and medical histories.

I hereby authorize any physician, health care practitioner, dentist, hospital or medical care facility to provide all information on the patient's history to Oral & Dental Implant Surgery.

I hereby authorize photocopies of this form to be valid and original.

I, the undersigned, hereby authorize payment directly to Oral & Dental Implant Surgery, of medical/surgical/dental benefits, if any, otherwise, payable to me under the terms of my insurance policy.

I fully understand that I am primarily and financially responsible for fees incurred. I further understand that payment to Oral & Dental Implant Surgery is not contingent of any settlement, judgement or verdict by which the patient may eventually recover said medical/surgical/dental fees.

I hereby agree that I, the undersigned, shall be liable for any reasonable attorney's fees and/or collection costs incurred by Oral & Dental Implant Surgery in the event that such medical/surgical/dental bills are placed with an attorney or other third party.

Pre-treatment estimates and benefits given over the telephone are not a guarantee of payment from your insurance company. Any insurance claims outstanding over 90 days becomes patient responsibility. Regardless of any estimated insurance coverage, they are based on benefits available at the time of service. I understand that any balance incurred will be my responsibility.

I am fully aware of the contents of this form and I am signing and agree to the credit policy of Oral & Dental Implant Surgery.

RESPONSIBLE PERSON ____

PATIENT/PARENT ________________________________ DATE ______________
Signature

PATIENT ________________________________ S.S. # ______________