PLEASE READ CAREFULLY

Dear Patient:

REGARDING YOUR PRIVACY

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Patient/Legal Guardian Date

IF YOU HAVE INSURANCE

As a courtesy, our office will assist you in submitting insurance forms to your insurance company.

However it is the patient's responsibility to pay for services if the claim is disputed and/or denied.

Please note that if professional services have not been paid by your insurance company within 90 days, you are responsible for payment.

By signing this form you indicate that you accept responsibility to pay for services rendered, if your insurance company does not pay for these services.

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to Maxillofacial Surgical Arts any benefits due me under my insurance policy for services rendered. I authorize the release of any medical and/or dental information necessary to process this claim.

_____

Patient/Responsible party Date