

ASSOCIATED ORAL SURGEONS, PA

DIPLOMATES AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY

PRACTICE LIMITED TO ORAL AND MAXILLOFACIAL SURGERY AND IMPLANT DLDGY

I hereby authorize direct payment of my insurance (medical or dental) benefits to the doctor who provided services indicated on the attached statement.

I understand that Associated Oral Surgeons, P.A., is filing the original claim for benefits at my request. It is my obligation to see that my insurance carrier pays its obligation as provided for in my plan. It is NOT the responsibility of Associated Oral Surgeons, P.A., to pursue my insurance carrier for payment. Should problems arise causing a delay in payment beyond thirty (30) days from the original date of filing, I understand and agree that it is my obligation to pursue my insurance company for its payment.

I understand that documents can be made available to me for any additional insurance benefits that I choose to file. I also understand that payment for the balance-due plus any additional charges for supplemental documents will be my responsibility. In the event that primary and/or secondary insurances have not paid after sixty (60) days from the date of service, all remaining balances are due in full and will be paid by me at that time. Any unresolved insurance issues become my responsibility as the patient or guarantor.

Should uninsured qualified patients or guarantors have financial issues, information is available that will assist them in their search for outside financing. Qualifying criteria for these arrangements are solely at the discretion of Associated Oral Surgeons and the final decision for the granting of credit is determined by the respective outside financial source.

I understand that an ESTIMATED down payment of the total fee will be required prior to services being provided. This amount may be increased due to unexpected larger than quoted deductibles or smaller than quoted benefit percentages. I understand that insurance carriers or third party plan administrators can only determine exact benefits once the final written claim is received. Any written preliminary or telephone quote provided by my carrier to Associated Oral Surgeons, P.A., is a preliminary estimate and NOT a guarantee of total payable benefits.

I understand that any costs of collection due to my default on this agreement will be added to my amount due and are payable in full. Any dishonored check will be assessed a \$40.00 returned check fee.

I fully understand and accept the above requirements and responsibilities.

Insured/Guarantor Signature Date

Patient Name (please print) Date