OFFICE POLICIES

1. PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.
2. INSURANCE BENEFITS **MUST** BE VERIFIED PRIOR TO THE DAY OF SURGERY (IF APPLICABLE)
3. FLORIDA ORAL & FACIAL SURGICAL ASSOCIATES RESERVES THE RIGHT TO ACCEPT OR DENY ASSIGNMENT OF INSURANCE.

I understand deductibles and co-pays are due on the date of service. If FLORIDA ORAL & FACIAL SURGICAL ASSOCIATES is not contracted with your insurance plan and your surgery does not total over $500.00, we require payment in full and will provide you with an itemized insurance receipt for your reimbursement. FLORIDA ORAL & FACIAL SURGICAL ASSOCIATES files insurance as a courtesy for our patients. We do our best to give you the most accurate estimate of your benefits. Insurance companies do not guarantee benefits over the telephone. If your insurance company does not pay your claim as expected, the responsible party is obligated for the balance of the account.

I hereby authorize payment directly to the doctor the insurance benefits otherwise payable to me.

Signed (Patient or Parent if Minor) Date

I authorize release of any information relating to this claim. I authorize the release of my records to my referring doctor and my insurance carrier. I understand that I am responsible for all costs of treatment.

Signed (Patient or Parent if Minor) Date

PAYMENT TODAY WILL BE: _____ CASH _____ CHECK _____ CREDIT CARD _____ DEBIT CARD

DO YOU HAVE INSURANCE? Y N _____ DENTAL _____ MEDICAL

PATIENT INFORMATION

PATIENT LAST NAME		FIRST NAME	MI	SEX	DOB	AGE
SOCIAL SECURITY #	MARITAL STATUS	HOME PHONE ( )	WORK PHONE ( )		CELL PHONE ( )	
ADDRESS		CITY		STATE	ZIP CODE	
EMAIL ADDRESS						
OCCUPATION	EMPLOYER NAME		CITY			STATE

BILLING INFORMATION

RESPONSIBLE PARTY FOR PAYMENT		SOCIAL SECURITY #	DOB	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER
MAILING ADDRESS		CITY		STATE / ZIP CODE
HOME PHONE ( )	WORK PHONE ( )		EXT	CELL PHONE ( )
SIGNATURE OF PARTY RESPONSIBLE FOR PAYMENT				DATE

INSURANCE INFORMATION

PRIMARY DENTAL	INSURED NAME	SOCIAL SECURITY #	DOB	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER
EMPLOYER'S NAME				GROUP NUMBER
INSURANCE COMPANY NAME				PHONE NUMBER ( )
SECONDARY DENTAL	INSURED NAME	SOCIAL SECURITY #	DOB	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER
EMPLOYER'S NAME				GROUP NUMBER
INSURANCE COMPANY NAME				PHONE NUMBER ( )
PRIMARY MEDICAL	INSURED NAME	SOCIAL SECURITY #	DOB	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER
EMPLOYER'S NAME				GROUP NUMBER
INSURANCE COMPANY NAME				PHONE NUMBER ( )
SECONDARY MEDICAL	INSURED NAME	SOCIAL SECURITY #	DOB	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER
EMPLOYER'S NAME				GROUP NUMBER
INSURANCE COMPANY NAME				PHONE NUMBER ( )