ORAL AND MAXILLOFACIAL
SURGERY OF THE LOWCOUNTRY

Permission for Treatment

THIS MUST BE SIGNED TO ALLOW FOR AN EXAM AND/OR SURGICAL TREATMENT

I ________________________________, hereby grant permission to the doctors and staff of Oral & Maxillofacial Surgery of the Lowcountry to perform such evaluations and/or treatment as may be deemed necessary or advisable in the diagnosis of my/or minor child's/ condition. The Medical History form is complete and accurate.

_____________________________________ Must be signed by patient or patient's guardian

Medical Authorization and Financial Understanding

In order to control the costs of treatment, payment is expected at the time of service. Please take a moment to read over our office policies and patient responsibilities listed below.

Due to the many changes occurring with medical and/or dental insurances we have no way of knowing what each patient's specific contract will or will not cover. All patients are responsible to contact their insurance company to verify that oral surgery procedures (in the office or in the hospital) are covered under their specific contract. If we have a participation agreement with your insurance company we will verify coverage and ***ESTIMATE*** your portion of the service to be paid at the time of surgery.

We do not have a participation agreement with your **medical** insurance company; therefore payment must be made in full at the time services are rendered for procedures covered by your medical insurance. We will submit insurance claims for you for possible reimbursement. If your insurance company sends payments to our office, a refund will be made to you promptly. If, for any reason, your insurance company issues a check to you that had not been estimated as your portion, we will ask that you sign over the check to our office or write us a check for that amount.

In the event any service is denied by your insurance company for any reason, even after verification of benefits, you will be responsible to pay this balance in full.

If your insurance company does not make payment within 120 days of the date services were rendered you will be responsible for payment to our office within the next 30 days. A 20% collection fee will be added to your account balance in the event it is turned over to an agency for collection.

I authorize Oral & Maxillofacial Surgery of the Lowcountry to release any necessary information for insurance claims to insurance companies. I permit a copy of this authorization to be used in lieu of the original and request payment of medical and/or dental benefits, either to myself or to Lowcountry Oral and Facial Surgery.

Without valid proof of medical and dental insurance at the time of service all services are payable at the time of your visit. Please bring your medical and dental insurance cards to the receptionist.

If legal action were necessary to collect any unpaid balances, all legal costs incurred in the process would be paid by the patient (guarantor if the patient is a minor). There is a $35.00 fee for returned checks.

Name: __________________________ Date:______________ Signature: __________________________

I also give consent for the use of photographs for educational purposes. o **Yes** o **No**