MARYLAND ORAL SURGERY ASSOCIATES

FINANCIAL INFORMATION

Primary Dental Insurance Company Name: _____

Subscriber's Name: _____ ***GENDER: (M) (F) DOB***: _____ ___

Member ID#: _____ Group #: _____

_____

Secondary Dental Insurance Company Name: _____

Subscriber's Name: _____ ***GENDER: (M) (F) DOB***: _____

Member ID#: _____ Group #: _____

_____

Medical Insurance *Company Name*: _____

Subscriber's Name: _____ ***GENDER: (M) (F) DOB:*** _____

Member ID#: _____ Group ID #_____

- WE ACCEPT CASH OR CREDIT CARD (Visa, MC, Discover, AMEX) NO PERSONAL CHECKS
- **A 48 working hours notice is required for the cancellation of a scheduled surgical procedure. A $50.00 cancellation fee will be charged to the patient if we do not receive notice in the appropriate time frame.**

I understand that Maryland Oral Surgery Associates is filing my insurance claim to my primary insurance as a **COURTESY**. Although Maryland Oral Surgery Associates extends this courtesy to me, I understand that obtaining payment by my insurance company is ultimately my responsibility. Pre-authorization by your insurance company is not a guarantee of the quoted benefit. **Insurance companies do not guarantee benefits until the claim is received**. Therefore, amounts collected by our office are **only an estimate** of benefits. I also understand that I am responsible for any co-payments and/or billable charges that are **not covered** and/or denied by my insurance company. I understand that I will receive a bill for all outstanding charges **30 days** after the date on which I received services regardless of the submitted insurance claim status. A 1.5% finance charge per month will be added to my existing account balance.

*I, _____ hereby authorize Maryland Oral Surgery
(Responsible Party Name)
Associates, P. A. to apply for benefits on my behalf for services rendered to me (or my minor child) and request that payment be made by _____ Insurance Company and
(Name of Insurance Company)
Payment is sent directly to Maryland Oral Surgery Associates, P.A. I understand that this, in no way, relieves me of my primary responsibility to pay for services rendered to me (or my minor child). If suit is filed, I agree to pay reasonable court costs, and other expenses incurred as a result of said collection. The undersigned agrees that should suit be filed, venue location of suit shall be in Montgomery County, Maryland, venue in any other counties being waived hereby. In the event that I am due a refund, Maryland Oral Surgery Associates will reimburse me within 45 days of the final insurance payment and adjustments made to my account.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____
(Patient or Responsible Party if a Minor)