ORAL SURGERY ASSOCIATES OF NORTH TEXAS, P.C.

Colin S. Bell, D.D.S., M.S.D. | Phillip R. Newton, D.D.S., M.D. | Max D. Finn, D.D.S., M.D.
Douglas J. Dingwerth, D.M.D., M.D. | William R. Walstad, D.D.S.

Consent For Insurance Release

We are committed to protecting your confidentiality and right to privacy. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain consent from you prior to releasing any information to your insurance agency. If you desire for us to prepare your insurance claim and ready it for mailing for you, we need your consent. This will also permit us to respond to requests by your insurance company for explanation of treatment necessity or radiograph duplication and forwarding. Both are common requests by insurance companies necessary to complete claim processing and reimbursement.

Please understand this in no way allows for us to release any information regarding you or your treatment to any contractors, employers, government agencies, or any other third parties, except when stipulated by law. This is a strict statement regarding provision of information to your insurance company for processing your claim for reimbursement.

_____ _____

Patient Signature Date

Insurance Information

Primary Insurance _____
Address _____
City _____ St ____ Zip_____
Phone# _____
Insured Name _____
Insured SS#_____Group # _____
Insured DOB_____Insured ID# _____
Employer _____
Is this ❑ medical or ❑ dental insurance?
Insured's
Relationship to Pt _____
If patient is over 18, is
PATIENT A STUDENT? _____
WHERE? _____

Secondary Insurance _____
Address _____
City _____ St ____ Zip_____
Phone# _____
Insured Name _____
Insured SS#_____Group # _____
Insured DOB_____Insured ID# _____
Employer _____
Is this ❑ medical or ❑ dental insurance?
Insured's
Relationship to Pt _____
If patient is over 18, is
PATIENT A STUDENT? _____
WHERE? _____

over

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED TODAY.

I AGREE TO MAKE PAYMENT BY: (_____CASH), (_____CHARGE), (_____CHECK).

_____

Signature

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I HEREBY AUTHORIZE PAYMENT OF BENEFITS TO DR. COLIN S. BELL, DR. MAX D. FINN, DR. WILLIAM R. WALSTAD, DR. DOUGLAS J. DINGWERTH AND/OR DR. PHILLIP R. NEWTON FOR SERVICES PERFORMED THAT OTHERWISE WOULD HAVE BEEN PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT, INCLUDING ANY LEGAL FEES, IF INCURRED, TO COLLECT ANY OUTSTANDING BALANCE.

_____ _____

Signature Date

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I UNDERSTAND THAT THE AMOUNT I AM PAYING IS AN ESTIMATE OF MY PORTION NOT COVERED BY INSURANCE AND THAT UPON PAYMENT OF THIS CLAIM A BALANCE MAY BE OWED BY ME AND WOULD BE PAYABLE AT THAT TIME.

_____ _____

Signature Date

With whom may we discuss your treatment?

_____ _____

Name Relationship

With whom may we discuss your financial arrangements?

_____ _____

Name Relationship