Oral and Maxillofacial Surgery Specialists, P.C.

Financial Obligation

I acknowledge that the financial obligation is between this office and myself and NOT dependent on insurance coverage. I agree to be responsible for all charges not covered by a benefit plan.

Should the account become delinquent, I understand that applicable late fees will also be my responsibility. These may include, but are not limited to, interest charges, $11.00 rebilling fees, court costs, attorney fees and collection costs.

I authorize payment of the benefits otherwise payable to me directly to Oral & Maxillofacial Surgery Specialists.

☐ _____ I do NOT have Medicaid or any other Public Assisted insurance company. Therefore I am
Initial

responsible for the financial obligation for Oral and Maxillofacial Surgery Specialists P.C.

_____ Date _____

Signature of Patient/ Guarantor

_____ Date _____

Authorized Signature for Practice

Card Present? Yes No

*Please print this form, review the policy and bring your copy to the office

Ron D. Thoman, D.D.S. Ryan D. Hambleton, D.M.D.

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Compassion Professionalism Competence