SARATOGA COUNTY ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, PLLC

HIPAA RELEASE OF INFORMATION

By signing below, I am giving permission for this office to discuss my care as indicated with the individual(s) listed. If they are not listed, no information will be provided to them.

Name: _____ Relation: _____

Information to Disclose: Treatment _____ Finances _____ Appointments_____

Name: _____ Relation: _____

Information to Disclose: Treatment _____ Finances _____ Appointments_____

Name: _____ Relation: _____

Information to Disclose: Treatment _____ Finances _____ Appointments_____

Name: _____ Relation: _____

Information to Disclose: Treatment _____ Finances _____ Appointments_____

_____
Patient or Legal Guardian Signature

_____
Printed Name

_____
Date

4 CARE LANE | SARATOGA SPRINGS, NY 12866
(518) 583-4497 | FAX: (518) 583-3779

947 ROUTE 146 | CLIFTON PARK, NY 12065
(518) 348-1915 | FAX: (518) 348-1916

1019 KEYES AVENUE | SCHENECTADY, NY 12309
(518) 280-1914 | FAX: (518) 280-5820

SARATOGA COUNTY ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, PLLC

PLEASE PROVIDE US WITH SOME INSTRUCTIONS ABOUT HOW WE SHOULD CONTACT YOU:

I understand that, in connection with my diagnosis and treatment, Saratoga County Oral & Maxillofacial Surgery Associates may from time to time wish to communicate to me medical, laboratory, appointment and other confidential information. In providing Saratoga County Oral & Maxillofacial Surgery Associates with a confidential home, cellular or other number and/or giving permission to leave a message for me at the home, cellular or other telephone number, I agree that such confidential information may be transmitted in that fashion without further notice to me, and I hereby authorize Saratoga County Oral & Maxillofacial Surgery Associates to do so. I understand that if my confidential home, cellular or other telephone number should change or become inoperative at any time, or if I wish to revoke permission for Saratoga County Oral & Maxillofacial Surgery Associates to leave a message for me at any of these numbers, it shall be my obligation to notify Saratoga County Oral & Maxillofacial Surgery Associates in writing of such change. In the absence of such notice, Saratoga County Oral & Maxillofacial Surgery Associates shall have no obligation to obtain alternate home, cellular or other telephone number for me or to refrain from leaving a message, nor shall it have any liability for transmittal to the confidential home, cellular or other telephone number provided here, or leaving a message for me at the home, cellular or other telephone number with regard to any medical, laboratory, appointment or other confidential information.

HOME TELEPHONE NUMBER: _____

OK TO LEAVE A MESSAGE AT THIS NUMBER: _____

CONFIDENTIAL CELLULAR NUMBER: _____

OK TO LEAVE A MESSAGE AT THIS NUMBER: _____

CONFIDENTIAL OTHER NUMBER: _____

OK TO LEAVE A MESSAGE AT THIS NUMBER: _____

_____
Patient or Legal Guardian Signature

_____
Printed Name

_____
Date

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Medicare Private Contract

By signing this contract, I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare or its agents for services provided by Saratoga County Oral & Maxillofacial Surgery Associates, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by Saratoga County Oral & Maxillofacial Surgery Associates and I understand that **no claims will be submitted to Medicare or its agents and no Medicare reimbursement will be provided for these services**.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.

I understand that Medigap plans do not and other health and medical care insurance plans may elect not to make payments for such services.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made and that I am not compelled to enter into private contacts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that Saratoga County Oral & Maxillofacial Surgery Associates is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on: 11/19/2016 and will expire on 11/19/2018.

_____

Patient or Legal Guardian Signature

_____

Printed Name of Patient

_____

Date

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FINANCIAL POLICY

If you do not have insurance, payment in full is expected at the time of service.

If you have insurance, we are anxious to help you receive your maximum allowable benefits. To achieve this, we need your assistance and your understanding of our payment policy. We participate with select dental and medical insurance plans. It is your responsibility to determine if your plan is among them.

Certain insurance plans require a written referral. It is the patient's responsibility to present a properly dated referral at the time of the office visit. Co-payments for all insurances are due at the time services are rendered.

Your insurance is a contract between you, your employer and your insurance company. Not all services are covered benefits in all contracts. Some insurance companies select services they will not cover. You may have a yearly maximum or a deductible. Insurance companies rarely reimburse 100% for oral surgical procedures. Generally they pay between 50% and 80% of the covered cost. We are happy to file insurance claims for you. *Our filing the claim on your behalf does not guarantee payment nor does a pre-determination of benefits represent a guaranty of payment.* We ask that payment **APPROXIMATING** your estimated percentage of the fee be made at the time of surgery. **Any charges not included in the payment received from your insurance company are your responsibility.**

- Your payment is due within twenty-eight (28) days of your receipt of our billing statement.
- A $5.00 re-billing fee will be imposed on open accounts over twenty-eight (28) days past due.
- There is a fee for all checks returned for insufficient funds and this is your responsibility.
- A 1% per month finance charge will be added to all outstanding balances over sixty (60) days past due.

We accept payment by check, credit card, money order or CareCredit. If an open balance is not collected and becomes delinquent *you* will be responsible for all collection agency fees and legal costs.

We bill your insurance company for the surgeon's fee only. Any services rendered outside of our office (i.e., pathology, labs, etc.) will be billed separately by each facility and those costs are your responsibility. We deal with many outside facilities and do not guaranty that any outside facility participates with your insurance or that all costs will be covered under your particular contract.

While the filing of insurance claims for surgery charges is a courtesy we extend to our patients, *all charges are your responsibility from the date the services are rendered*. Our relationship is with *YOU* and not your insurance company. **I authorize and direct payment of dental and/or medical benefits payable on my behalf directly to Saratoga County Oral & Maxillofacial Surgery and its providers.**

_____

Patient or Legal Guardian Signature

_____

Printed Name

_____

Date

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