Oral and Maxillofacial Surgery Associates of Western New York, P.C.

*DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGEONS

*Edward M. Boyczuk, D.M.D.
*N. Mario DiNardo, D.M.D.
*Michael P. Boyczuk, D.D.S.
* Fred J. Rodems, D.D.S.
* William S. Boyczuk, D.D.S., M.D.

PATIENT NAME:_____ MALE OR FEMALE:_____

ADDRESS:_____

CITY:_____ ZIP:_____

DATE OF BIRTH:_____ AGE:_____

SOCIAL SECURITY #:_____ PHONE#:_____

EMPLOYER:_____ PHONE#:_____

GENERAL DENTIST:_____ REFERRED BY:_____

MEDICAL PHYSICIAN:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____ DATE OF BIRTH:_____

ADDRESS IF DIFFERENT:_____

CITY:_____ ZIP:_____

SOCIAL SECURITY #_____

EMPLOYER:_____ WORK #:_____EXT:_____

DENTAL INSURANCE (PRIMARY):_____

ADDRESS:_____

ID#:_____ GROUP#:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____

DENTAL INSURANCE
(SECONDARY):_____

ADDRESS:_____

ID#:_____ GROUP#:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____

MEDICAL INSURANCE:_____

ADDRESS:_____

ID#:_____ GROUP#:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____

I understand that I am responsible for all patient charges and hereby authorize release of information and x-rays regarding the services rendered to the insurance company. We do accept Visa, Master Card, Discover, Care Credit, check and cash.
PLEASE NOTE: INSURANCE POLICIES ARE CONTRACTS BETWEEN THE PATIENT AND THE INSURANCE COMPANY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR FULL PAYMENT OF THIS ACCOUNT WITHIN 60 DAYS.
I understand I will be charged for any outside collection costs or attorney/court costs should this account be turned to an outside agency. 1.5% SERVICE FEE ACCRUED MONTHLY ON ALL BALANCES GREATER THAN 90 DAYS OLD.
I also authorize all insurance benefits to be paid directly to the doctor.

X _____

SIGNATURE OF RESPONSIBLE PARTY

Oral and Maxillofacial
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www.oralsurgeryofwny.com

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INSURANCE WAIVER:

PLEASE READ

Welcome to our practice. Our wish is to be sure your visit meets your expectations in every way. With this, we want to be sure you understand our office financial policies and the involvement of your insurance as payment, for your care today and in the future.

1.) If you are enrolled in any type of INSURANCE PLAN, it is your responsibility to check with your insurance carrier to see if we are participating in your particular plan. There are certain insurance companies that have numerous subsidiaries within them, i.e. Aetna, Cigna and Excellus, that we do not participate with. It is your responsibility to check with your insurance for coverage.

2.) Please understand that certain procedures may not be covered or will be considered not necessary by your insurance company. Any treatment that falls into these categories will be your responsibility for payment in full.

3.) If you have MEDICARE: Medicare does not cover dental care. If you are over 65 years of age with no dental coverage, we do offer a senior citizens discount. If you are having a MEDICAL procedure in our facility, we will bill MEDICARE for you, however, we do not participate with Medicare and the Medicare reimbursement will come directly to you. Payment in full will be required the day of service.

4.) You are directly responsible for your account in our office. We will bill your insurance carrier as a courtesy. Every surgical patient seen in our facility will be asked to give a deposit prior to care, regardless of insurance coverage. We ask that you follow-up on your insurance claim and call our office should you need your claim resubmitted for any reason.

We do not accept Workers Compensation, No-Fault and Medicaid.
We are happy to submit an insurance pre-determination prior to any surgery at your request.

ALL OF MY QUESTIONS HAVE BEEN ANSWERED REGARDING THE FINANCIAL ASPECT OF MY ACCOUNT.

_____ _____

Guarantor Signature Date