SOUTH SHORE ORAL SURGERY ASSOCIATES

DR. STEVEN J. VERVENIOTIS | DR. RICHARD M. MIRRA | DR. MATTHEW GREEN

Office & Financial Policy

PATIENT INFORMATION

First Name		Last Name		Birth Date	

Please initial each line and sign at the bottom:

______ I authorize the release of any dental, medical, or any other information including x-rays that may be requested by other professional offices.

______ I authorize the release of any dental, medical, or any other information including x-rays that may be necessary to process my insurance claim (if applicable).

______ I have been made aware by South Shore Oral Surgery that my records will be held in the strictest confidence according to the HIPAA privacy regulations.

______ I am aware if my dental insurance requests a denial from my medical insurance carrier prior to processing my dental claim, that South Shore Oral Surgery **does not** participate with any medical insurance companies and **does not** file medical insurance forms. Therefore, I am responsible for the fees and any attempt to recover funds from the medical insurance company.

______ I am responsible for any remaining balance of my procedures that my insurance doesn’t cover (if applicable).

______ If it is necessary for my account to be turned over to an attorney/collection agency, I will assume all charges incurred by South Shore Oral Surgery.

FORM COMPLETION

I have read and understand the above information. By my signature below, I acknowledge my financial responsibility for all fees incurred regardless of my insurance reimbursement.

Signature of Patient, Parent or Legal Guardian		Date	

IF PATIENT IS A MINOR

Printed Name		Relationship to Patient	