Established 1918
Fellow
American Association of
Oral and Maxillofacial Surgeons
Diplomate
American Board of
Oral and Maxillofacial Surgeons

Northern Kentucky Oral and Maxillofacial Surgical Associates P.S.C.

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Patient Name _____

I hereby authorize treatment of the patient above by the physicians and employees of Northern Kentucky Oral and Maxillofacial Surgery Associates, for medical and surgical procedures and related services on a scheduled or emergency basis. I agree to take full steps necessary for the submission of insurance claims relating to services provided by the office of Northern Kentucky Oral and Maxillofacial Surgery Associates, for the patient named above. I authorize payment of benefits to the Northern Kentucky Oral and Maxillofacial Surgery Associates. I certify that I have been informed that health or dental insurance may not exist for services for any of the following reasons:

- I may have a pre-exsisting condition or other diagnosis that may not be covered by my health care plan.
- I have not obtained a necessary referral from my health care plan.
- My health care plan may not have established medical necessary for the services.
- There is an unmet deductible under the plan.
- The services are not covered under my health care plan.

With the above knowledge, I request that services be performed and I agree that I am ultimately responsible for the charges incurred by me. If services are not covered by my insurance plan I am responsible for the remaining balance. If the insurance estimates an amount that they will not cover, I will pay that upfront. I am aware that it is only an estimate and they may not pay anything at all, or only some of what they estimate to pay. If a balance is due, I will pay it within reasonable time or legal action will be taken to insure payment. In the event that my account becomes delinquent or past due, I understand that I am responsible for all collection fees, interest accrual, attorney fees, or court costs.

I also give permission to send lab reports, X-rays and Dr's notes to the insurance companies in order for a decision of their payment to be made on the claim. I also give permission for lab specimen's, if any are taken, may be sent to whatever lab necessary in order to determine diagnosis.

I acknowledge that I have been given the opportunity to review a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice, and understand that a copy will be made available to me upon request.

_____ _____

Signature Date