

ASSIGNMENT & RELEASE – TREATMENT & RECORDS

- I agree to permit authorized personnel of Dental Surgical Center of Medina, Inc. to perform treatment under anesthesia, examinations, laboratory tests, and emergency procedures as deemed necessary by the doctors at this facility.
Patient has advance directive: (Do not resuscitate) Yes No
- The Dental Surgical Center of Medina does not honor advance directives (Do not Resuscitate clause). All emergency procedures are performed to guidelines and, if necessary, patient will be transported to nearby hospital.
- I hereby assign my insurance benefits to be paid directly to the Dental Surgical Center of Medina. I also authorize the attending physician and his/her designee to release information acquired in the course of my examination and treatment necessary to process claims and/or provide care.
- I acknowledge receiving a copy of the “**Notice of Privacy Practices**”.

I agree that this authorization is valid regardless of when I receive services at this office and that I am the patient or authorized to sign this document.

Patient or Authorized Party Signature

Date

FINANCIAL AND MANAGED CARE POLICY STATEMENT

Dental Surgical Center of Medina, Inc. adheres to the policies below. The patient/responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing the doctor.

- Patients with an insurance co-payment are expected to make payment when checking in for the appointment.
- Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
- Not all services are covered benefits of all insurance plans. The patient/responsible party maintains the responsibility of verification of applicable coverage.
- Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.
- Dental Surgical Center of Medina, Inc. does not bill third parties in legal situations or injuries. We will bill your health insurance. Any balance unpaid by your health insurance will be billed to the guarantor on the patient account.

We accept cash, personal checks, and credit cards (Visa, MasterCard, and Discover). Returned checks and balances older than 45 days may be subject to additional collection fees.

We encourage you to communicate with our billing staff any temporary financial problems my affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today’s appointment. Thank you for your understanding and cooperation with this policy.

I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.

Patient/Responsible Party Signature

Date