Midwest Oral & Craniofacial Specialists

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Financial Agreement & Patient Authorizations

Financial Agreement
Payment for all services to patients without medical or dental insurance will be due and payable at the time of service unless arrangements have been made prior to the appointment. Patients with medical or dental insurance will be responsible for all applicable copays, coinsurance, and deductibles at the time of service. Our doctors do contract with most major medical insurance carriers. Pre determinations will only be filed upon request. Our offices accept Mastercard, Visa, Discover, American Express, checks, and cash. Financing is offered through Care Credit and Cherry. In accordance with government guidelines, a current driver's license or photo ID must be presented at the time of the appointment.

Assignment of Insurance Benefits
I hereby assign benefits to be paid, on my behalf, to the physician who renders service to me. I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or other third-party payer and certify that the information given with regard to insurance coverage is complete and accurate.

Release of Information
I authorize the physician rendering service to release all or part of my medical records when required for the submission and processing of any insurance claims. I release the physician, the practice, and their employees or agents from any liability arising from the release of such information for this purpose.

Disclosure Agreement
I acknowledge that I have been informed that the physician who is rendering services has an ownership interest in the above referenced facility. I have been advised that I may receive treatment at another facility but have voluntarily chosen to receive treatment at Midwest Oral and Craniofacial Specialists.

Electronic Check Notice
Notice: Your check will be processed electronically.
Each remittance by check is considered authorization to deposit it electronically. If the check is unable to be converted it may be processed as a draft against your account.

Certificate

The undersigned certifies that they have read and understand the foregoing and fully accepts the terms as specified above.

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Patient Signature OR Signature of Guardian/Responsible Party Date

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Patient Printed Name (AND Printed Name of Patient's Legal Representative if Applicable)