DATE: _____

I AGREE THAT BY NOT PROVIDING THE OFFICE WITH ACCURATE COMPLETE INSURANCE INFORMATION PRIOR TO TREATMENT RELEASES THE OFFICE FROM RESPONSIBILITY AND NEGATES MY RIGHT TO SEEK RECOURSE FROM THE OFFICE. IF I FAIL TO PROVIDE A PROPER REFERRAL REQUIRED BY MY INSURANCE CARRIER PRIOR TO TREATMENT, I ASSUME RESPONSIBILITY FOR ALL FEES INCURRED AND WAIVE MY RIGHT TO SEEK REIMBURSEMENT FROM THE OFFICE.

Signature: _____

SOMETIMES DURING SURGERY IT MAY BE NECESSARY TO OBTAIN A SPECIMEN FOR SUBMISSION TO A LABORATORY. PLEASE ADVISE THE STAFF PRIOR TO TREATMENT IF YOUR MEDICAL INSURANCE CARRIER REQUIRES THE SPECIMEN TO BE SUBMITTED TO A PARTICULAR LABORATORY. IF NO INFORMATION IS SUPPLIED THE SPECIMEN WILL AUTOMATICALLY BE SENT TO LIJ ORAL PATHOLOGY DEPT. A FEE WILL BE ASSOCIATED FOR THE ANALYSIS. COVERAGE MAY NOT BE AVAILABLE THROUGH YOUR CARRIER. YOU WILL BE RESPONSIBLE FOR THE FEE.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FEES ASSOCIATED WITH SUBMISSION OF A SPECIMEN. I HAVE HAD THE OPPORTUNITY TO SUPPLY MY MEDICAL INFORMATION TO THE OFFICE.

Signature: _____

CONSENT FOR TREATMENT

I HEREBY GRANT AUTHORITY TO DR. RUVINSKY AND STAFF TO PERFORM PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF MY CONDITION INCLUDED BUT NOT LIMITED TO X-RAYS, ANESTHETICS AND ANY ADDITIONAL TESTS AND EXAMINATIONS.

I CERTIFY THAT ALL OF THE INFORMATION I HAVE GIVEN IS CORRECT AND ACCURATE.

Signature: _____

AUTHORIZATION

I AUTHORIZE THE OFFICE TO RELEASE ANY INFORMATION INCLUDING, BUT NOT LIMITED TO, PANORAMIC FILMS, MEDICAL RECORDS AND ANY ADDITIONAL INFORMATION PERTINENT TO MY TREATMENT TO MY GENERAL DENTIST, INSURANCE COMPANY'S CUSTOMER SERVICE REPRESENTATIVE OR ATTORNEY TO FACILITATE COLLECTION UNDER THIS AUTHORIZATION.

Signature: _____

ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE TOTAL AMOUNTS DUE THE OFFICE FOR THEIR SERVICES. I UNDERSTAND THAT A CONSULTATION, PANOREX OR OTHER FILMS GENERATE A FEE THAT I AM RESPONSIBLE FOR AT THE TIME OF SERVICE. I FURTHER UNDERSTAND AND AGREE THAT THIS ASSIGNMENT DOES NOT CONSTITUTE ANY CONSIDERATION FOR THE OFFICE TO AWAIT PAYMENTS AND THEY MAY DEMAND PAYMENT FROM ME IMMEDIATELY UPON RENDERING SERVICES AT THEIR OPTION. THIS OFFICE DOES NOT ACCEPT POST-DATED CHECKS. A VALID NYS DRIVER'S LICENSE IS REQUIRED FOR ALL CHECKS.

Signature: _____