PAYMENT AUTHORIZATION

I hereby give full authorization to Tysons Corner Oral & Facial Surgery and its associates to seek payment from my insurance carrier(s). Igive them authorization to release my personal medical and non-medical information to my insurance carrier(s). I also give them permission to make copies of my records and radiographs to share with my insurance carrier(s), my primary care physician, and my general dentist/referring doctor. I will not hold Tysons Corner Oral & Facial Surgery liable, in any way, shape, or form, for release of my information for purposes of communicating with my insurance carrier(s), doctors, dentists, or other providers. I understand that, as a courtesy, Tysons Corner Oral & Facial Surgery will verify my coverage, send my claims, and give me an estimate of my copay. Tysons Corner Oral & Facial Surgery can never guarantee third party payment. Any unpaid balance from my insurance company will be my responsibility.

HIPAA DISCLAIMER

Ihereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices and/or given access to the notice. I have been afforded the right to review the notice, as required by the privacy regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have read and fully understand the privacy practices document provided by Tysons Corner Oral & Facial Surgery. I also hereby give full authorization to Tysons Corner Oral & Facial Surgery and its associates to release my personal medical and non-medical information to my insurance carrier(s). I also give them permission to make copies of my records and radiographs to share with my insurance carrier(s), my primary care physician, and my general dentist/referring doctor. I will not hold Tysons Corner Oral & Facial Surgery liable, in any way, shape, or form, for release of my information for purposes of communicating with my insurance carrier(s), doctors, dentists, or other providers.

RADIOGRAPH/CT-SCAN DISCLAIMER

I understand that if x-rays/radiographs (including Cone Beam CT-scan, panorex, or other individual films) are taken of me, the x-rays are solely to help the provider with his treatment plan. I understand that the provider is not a radiologist, nor is he certified to make a full diagnostic reading of all the x-rays, especially the Cone Beam CT-scan. In order to have the x-rays/CT-scan read with a formal report, I would have to have a radiologist perform a formal reading/interpretation, at my own cost and effort. Again, I completely understand that the purpose of the image(s) is mainly to look at the area(s) of interest. I do not and will not hold the provider(s) responsible for a formal interpretation/reading of the entire cone beam/CT-scan or other x-rays/radiographs taken of me.

AUTHORIZATION FOR PHOTOGRAPHS

I understand that if I am a cosmetic, orthognathic, pathology, or other complicated surgical patient, it may be necessary for the surgeon to take photographs. I hereby authorize Tysons Corner Oral & Facial Surgery and its associates to take photographs of me, if necessary. I understand that these photographs may be used for academic and non-academic purposes. I release ownership of the photographs and allow Tysons Corner Oral & Facial Surgery to use the photographs at their discretion. I do not hold them liable for this use, in any way, shape, form, or substance.

MISSED APPOINTMENT POLICY

Tysons Corner Oral & Facial Surgery reserves long blocks of appointments for surgeries and other procedures. As a courtesy to our doctors and to other patients (who are trying to be seen earlier), we ask that you give our office at least 72 hours prior notice; if you plan on cancelling or changing your appointment. We would be more than glad to assist you in rescheduling your appointment, especially when ample notification is given to us to readjust the schedule. Failure to do so, may result in a $100 failed appointment fee. After two failed appointments, Tysons Corner Oral & Facial Surgery reserves the right to cancel your procedure in entirety and refer you to another office/provider.

CONSENT FOR PROCEDURE

I hereby authorize the surgeon to perform a complete examination and evaluation. I hereby authorize the doctor or designated staff member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize any necessary life-saving procedures to be performed in the event of an emergency during a procedure. I agree to fully disclose my past medical history to the surgeon and associates, including medications and allergies, to help prevent such emergencies from occurring.

PAST DUE ACCOUNTS

Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the portion the insurance does not cover. Please be aware that some insurance companies may not cover all services performed at our office. The patient/guarantor is responsible for all charges that are denied or unpaid by your insurance carrier. If for some unforeseen reasons your insurance carrier has not made a payment within 45 days, the patient/guarantor is responsible for these charges. If payment is not received within 90 days and no financial arrangement has been made, your account will be turned over to a collection agency and you will accrue 33.5% collection fees and attorney fees in addition to your overdue balance. A monthly interest rate of 1.5% (18% APR) will be incurred for accounts 60 days past due. By signing below, you agree that you are liable for all collection charges, including but not limited to, attorney and legal fees. A fee of $25 will be charged for each returned check.

I CONFIRM THAT I UNDERSTAND THE ABOVE OFFICE POLICIES AND FINANCIAL AGREEMENTS. I AM A NATIVE SPEAKER OF ENGLISH OR HAVE BEEN OFFERRED THE SERVICES OF A QUALIFIED TRANSLATOR WHO HAS EXPLAINED THE INFORMATION IN MY NATIVE LANGUAGE. I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE OFFICE POLICIES AND FINANCIAL AGREEMENTS.

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SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE DATE

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WITNESS TO SIGNATURE