Oral, Facial & Implant
Surgical Center of South Florida
Diplomates American Board of Oral & Maxillofacial Surgery

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FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **Date of Birth**:_____

1. I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits.

2. I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, preventive exam, lab testing, x-ray, and any other screening service or diagnostic testing ordered by the physician.

3. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts usual and customary limit, or any type of benefit limitation for the services I agree to make full payment whenever required.

4. I understand and agree it is my responsibility to know if physician or provider I am seeing is contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

5. A deposit of $50.00 is required when scheduling surgery. If the appointment is cancelled less than 24 hours the deposit will be forfeited.

6. I understand that if I need a copy of my medical records, a printing fee will be charged.

7. I understand that I will be required to provide a valid form of payment, either check or credit card.

8. I understand that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated.

Signature: _____ **Date**: _____
(Please sign here – Patient or Responsible party)

Responsible Party Name:

_____
(Print name of responsible party)