RED ROCK ORAL & MAXILLOFACIAL SURGERY CENTRE
Mark I. Degen, D.D.S., M.D.

PATIENT INFORMATION

Name:_____ Nick Name:_____
(Last) (First) (M.I)

Address:_____
(Street) (City) (State) (Zip code)

D.O.B:_____ SSN #:_____

Employer:_____ Occupation:_____

Cell #:_____ Home #:_____ Work #:_____

Treating Dentist:_____ Phone #:_____

Who may we thank for referring you to our office/how did you hear about us?_____

Who is Financially responsible for this account?_____

PRIMARY DENTAL INSURANCE

Insurance Company's Name:_____ INS Phone #:_____

Policy Holder's Name:_____
(Last) (First) (M.I.)

D.O.B:_____ Member ID/SSN #:_____ Group #:_____

Employer/Company:_____ Occupation:_____

Policy Holder's Address:_____
(Street) (City) (State) (Zip code)

Patient's Relationship to Insured:_____Self_____Spouse _____Child_____Other:_____

SECONDARY DENTAL INSURANCE

Insurance Company's Name:_____ INS Phone #:_____

Policy Holder's Name:_____
(Last) (First) (M.I.)

D.O.B:_____ Member ID/SSN #:_____ Group #:_____

Employer/Company:_____ Occupation:_____

Policy Holder's Address:_____
(Street) (City) (State) (Zip code)

Patient's Relationship to Insured:_____Self_____Spouse _____Child_____Other:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or the above information.

_____ _____
Signature Patient/Legal Guardian if Minor Date

RED ROCK ORAL & MAXILLOFACIAL SURGERY CENTRE
Mark I. Degen, D.D.S., M.D.

Office Financial Policy

Patient's Name:_____ Account #:_____

We welcome you to Red Rock Oral & Maxillofacial Surgery Centre. Our primary concern is to provide quality and services to all our patients. To help us to achieve this goal, we would like for you to understand our financial policies.

Our office will file insurance claims for you as a courtesy. If there are services your insurance plan does not cover, you will be responsible for the unpaid balance. All charges are your responsibility whether your insurance company pays or not. You must provide us with the correct billing information regarding your insurance and inform us of any changes immediately. You are responsible for knowing the policies of your insurance plan(s), including co-pays, deductibles, and when prior authorization is required for tests or surgery. Every insurance policy is different and knowing what your insurance covers or disallows will aid in making your visit here a positive experience.

All payments are due at the time services are rendered. You will not be charged for immediate post-operative care. Additional charges will be applied to your account for any x-rays required during post-operative care. We will assist you in obtaining authorization and pre-estimates for any proposed surgery. If you have no received a call from us within 2-3 week period, please contact our office and we will call your insurance to check the status. If you decide not to wait for the insurance pre-determination to return, you will be required to pay additional fees up front which will apply towards your account balance. Any outstanding balance that has not been paid within 90 days from the date of service will accrue a finance charge of two (2%) per month interest. twenty four (24%) per year. A collection notification will be sent to delinquent accounts after 90 days from the last day which treatment was rendered. Please contact us if you feel a refund is required. Refunds are returned once per month. We are here to assist you in any way possible. please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience. If for any reason you cannot keep a surgical appointment, you must call our office and speak with an office employee at least 48 hours in advance of your scheduled appointment, otherwise, you will be charged $50.00.

Assignment of Benefits and Release of Information

I authorize Mark I. Degen, D.D.S., M.D.M Ltd. dba Red Rock Oral & Maxillofacial Surgery Center and associated staff to bill my insurance directly for any services rendered. I understand that I am financially responsible for all charges not paid by my insurance company including co-pays, deductibles, and any other charges that my insurance company denies. I agree to pay these charges at the time of service. I authorize Dr. Mark Degen and associated staff to furnish necessary information from my confidential medical record to the following: physicians requesting information for consultation, patient's health insurance carriers for reimbursement of fees and/or any third party which may be liable for all or part of the patient's physician fee.

_____ _____
Print of Responsible Party Date

_____
Signature of Responsible Party