ORAL-FACIAL RECONSTRUCTION AND IMPLANT CENTER
100 NW 82nd Avenue, Suite 102, Plantation, Florida 33324
21110 Biscayne Blvd., Suite 305, Aventura Florida 33180
975 Arthur Godfrey Road, Suite 204, Miami Beach, Florida 33140
1 SW 129th Avenue, Suite 400, Pembroke Pines, Florida 33027
5531 N. University Drive, Suite 104, Coral Springs, Florida 33067

DISCLOSURE AND ACKNOWLEDGMENT FORM

I hereby attest and affirm that:

1. The services set forth in the medical bills on this date were actually rendered.
2. I understand that I have the right and the affirmative duty to confirm tat the services for which I am being billed for, or are being billed to my insurance carrier have actually been rendered.
3. I was not solicited by any person to seek any services from the above named medical provider.
4. The physician, other licensed professional, clinic, or other medical institution rendering services, for which payment is being claimed, have explained the services rendered to me.
5. I understand that, if I notify the insurer in writing of a billing error, I may be entitled to a certain percentage of the reduction in the amounts paid by my motor vehicle insurer.
6. I understand that the physician, other licensed professional, clinic or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to me.

_____ _____

Signature of insured, patient or guardian Date

_____ _____

Signature of Licensed Medical Professional Date