ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER

DISCLAIMER NOTICE - FACTS YOU SHOULD KNOW ABOUT YOUR INSURANCE

By signing below, I acknowledge that I understand the following:

1. Under Florida law, physicians/dentists are generally required to carry malpractice insurance, otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Your doctor may have decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

2. I hereby assign the doctors at Oral Facial Reconstruction and Implant Center any benefits under any policy of insurance, indemnity agreement or any other collateral source as defined in Florida statue 768.76 for any services and/or charges provided by the doctors at Oral Facial Reconstruction and Implant Center. It is the intent of the undersigned that this assignment is irrevocable and shall apply to any and all causes of actions, suits, demands, claims and counter-claims.

3. I hereby authorize my attorney to release my settlement disbursement agreement to the doctors at Oral Facial Reconstruction and Implant Center

4. Many Insurance companies require a consultation first before any treatment can be rendered.

5. Many Insurance companies require prior authorization for any kind of procedure. Some insurance companies may take 3 to 5 weeks for this process.

6. **Dental Insurance is not meant to pay for all your dental treatment**. Many times it just helps you with your bill.

7. Many services are **NOT** covered by your insurances and due to the many changes in insurance policies; it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We provide you with an estimate but **cannot** guarantee accuracy on how much the final bill will be. We will submit your claims and will try to get the maximum benefit that your plan provides for you, but it will be **your** responsibility for all the charges not paid by your insurance. Therefore, we urge you, the patient, to please check with your insurance company regarding your coverage. It is **your** responsibility to know your individual coverage and its limitations. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company. We encourage you to read your policy to become more familiar with it. If you have any questions on how much or how often your insurance is going to pay on a procedure, you should contact your insurance company for details.

8. Once your procedure has been authorized, you will receive a phone call scheduling your surgery. Remember, your authorization is only good for a limited amount of time. Therefore you must be scheduled before the time limit expires.

9. If you are having IV sedation or general anesthesia, make sure you have nothing to eat or drink after midnight the night before your surgery, not even water.

10. **Cancelled appointments** within 48 hours of notice or no shows **will be charged $50.00 immediately**. We understand that emergencies do occur and we are willing to work with you. We have reserved this time **only for you** so if you need to reschedule an appointment **please** gives us a **call within 48 hours**.

11. If my records are requested by myself I will be requested to pay the office $1.00 per copy and $25.00 per x-ray duplicate.

12. **COLLECTION COSTS CLAUSE:** I agree, in the event that it becomes necessary to collect monies owed, I will be responsible for all cost including, but not limited to court costs, interest and attorneys' fees.

Patient's (Or Legal Guardian's) Signature	Print Name	Date
Witness	Print Name	Date