Schaumburg Oral & Maxillofacial Surgery, Ltd.

Mark L. Banakis, DDS ▪ Gregory E. Doerfler, DDS

Diplomates American Board of Oral and Maxillofacial Surgery

999 N. Plaza Drive • Suite 102 • Schaumburg, Illinois 60173 • 847/882-9448 • Fax 847/882-9496 • info@schaumburgoms.com

I. PATIENT INFORMATION

Name_____ Date of Birth:_____ Age: _____ Sex: M ___ F ____

Address_____Marital Status: Single__Married__Divorced__ Widowed___

City_____ State_____ Zip Code_____

Home Phone Number_____ Cell Phone Number:_____

Employer Name_____Work Phone Number:_____

Are you a student?_____ Where: _____ _____Full-Time_____ Part-time_____

Email Address: _____

Emergency Contact _____ Phone No. _____ Relationship _____

Whom may we thank for referring you? _____ *Dentist:* _____

II. GUARANTOR/PERSON RESPONSIBLE FOR PAYING ON ACCOUNT (must be present at appointment)

Name_____ Date of Birth_____Sex: M ____F_____

Address_____Relationship to patient_____

City_____ State_____ Zip Code_____

Employer Name_____Home Phone_____ Work Phone _____

III. PRIMARY INSURED INFORMATION

Name_____ Date of Birth_____Sex: M___ F___

Address_____ Relationship to patient_____

City_____ State_____ Zip Code_____

Social Security No._____

Employer Name_____Home Phone_____ Work Phone _____

Insurance Company_____ Medical_____ Dental_____ Both_____

PLEASE TURN OVER...SIGNATURE REQUIRED

IV. SECONDARY INSURED INFORMATION

Name_____ Date of Birth _____ Sex: M____ F____

Address_____Relationship to Patient_____

City_____ State_____ Zip Code_____

Social Security No._____

Employer Name_____Home Phone_____Work Phone_____

Insurance Company _____ Medical _____ Dental _____ Both_____

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, MasterCard, Visa, Discover, American Express and CareCredit. Returned checks will be issued at $25 return fee. **All balances are due in full within 30 days of service regardless of insurance coverage.** All fees incurred in the collection of past due accounts are the responsibility of the patient or guarantor.

We will be happy to help you process your insurance claim for your reimbursement. However, please realize:

- YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. Schaumburg Oral & Maxillofacial Surgery, Ltd. is not a party to that contract. We are not "Participating Providers" with all plans and therefore are considered "Out of Network" with most insurance.

- Our fees are generally considered to fall within the acceptable range by the majority of insurance companies. Therefore our fees are generally covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "UCR" is definded as usual, customary and reasonable for this region. Thus, our fees are generally considered usual, customary and reasonable by the majority of insurance companies.

  The "UCR" may not apply to companies who reimburse based on an arbitrary "schedule of fees" which bears no relationship to the current standard and cost of care in this area.

- Not all services are a covered benefit in all insurance policies. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental care provider, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us for assistance in the management of your account.

I authorize the payment of my dental/medical benefits to be paid directly to the doctor providing my care. In the event I default and do not make payments in accordance to the financial policy of this office, I am responsible for all costs of collection including attorney fees. In cases of divorced parents, and notwithstanding the terms of a Judgment or Decree of Divorce to the contrary, the parent accompanying the child at the time of service who signs as Guarantor herein below shall be deemed to be the parent financially responsible for payment herein.

_____ (Patient Signature) _____ (Date)

_____ (Signature of Parent or Guarantor)

If you have any questions about the above information PLEASE, let us know. Thank you for choosing Schaumburg Oral and Maxillofacial Surgery for your care!

Schaumburg Oral & Maxillofacial Surgery, Ltd.

Mark L. Banakis, DDS ▪ Gregory E. Doerfler, DDS

Diplomates American Board of Oral and Maxillofacial Surgery

999 N. Plaza Drive • Suite 102 • Schaumburg, Illinois 60173 • 847/882-9448 • Fax 847/882-9496 • info@schaumburgoms.com

PRIVACY STATEMENT (HIPAA)

I authorize this practice to disclose protected health information to any health/dental care provider who has referred me and to other parties (insurance companies, healthcare facilities and hospitals) for the purposes of treatment, payment or health care operations. I have been informed of the privacy practice of this office; which is posted in the waiting room and I am aware of my right to a copy of this notice.

_____ _____

(Patient) ***(Date)***

_____ _____

(Guarantor) ***(Date)***

Schaumburg Oral & Maxillofacial Surgery, Ltd.

Mark L. Banakis, DDS ▪ Gregory E. Doerfler, DDS

Diplomates American Board of Oral and Maxillofacial Surgery

999 N. Plaza Drive • Suite 102 • Schaumburg, Illinois 60173 • 847/882-9448 • Fax 847/882-9496 • info@schaumburgoms.com

Patient Disclosure Instructions

Schaumburg Oral and Maxillofacial Surgery is committed to keep communications regarding your health information confidential. To accomplish this, please advise us of the following:

I wish to be contacted in the following manner *(check all that apply)*:

☐ Home Telephone_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

It is best to confirm my appointment(s) by calling:

☐ Home Telephone ☐ Work Telephone ☐ Cell Phone

I allow you to give my clinical information to or answer questions from (*check all that applies*):

☐ Spouse ☐ Parent ☐ Child ☐ Other (specify):_____

☐ None

_____ _____

*(Patient Signature-if **under** 18 years parents signature)* *(Date)*

_____ _____

(Print Patients Name) *(Birth Date)*

These requests shall remain valid until revoked by patient only upon written notice to Schaumburg Oral and Maxillofacial Surgery.