Wood & Myers
ORAL AND MAXILLOFACIAL SURGEONS

YOUR INFORMATION

FULL LEGAL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

CELL PHONE: _____ HOME PHONE: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

GENDER: MALE / FEMALE / NON-BINARY / TRANSGENDER

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED

EMPLOYMENT STATUS: FULL TIME / PART TIME / RETIRED

EMPLOYER: _____

STUDENT STATUS: FULL TIME / PART TIME

NAME OF SCHOOL: _____

RETURNING PATIENT: YES / NO

DENTIST OR PROVIDER WHO SENT YOU TO OUR OFFICE TODAY: _____

YOUR EMERGENCY CONTACT

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

YOUR TRUSTED PERSON FOR RELEASE OF INFORMATION

When required, I permit Wood & Myers to provide all my information regarding medical & dental treatment including financials to:

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

Wood & Myers
ORAL AND MAXILLOFACIAL SURGEONS

YOUR HEALTHCARE PROVIDERS AND INSURANCE COVERAGES

1. GENERAL DENTIST/ PRACTICE NAME:_____

ADDRESS / PHONE NUMBER:_____

2. MEDICAL PHYSICIAN NAME:_____

ADDRESS / PHONE NUMBER:_____

3. SPECIALIST NAME:_____

ADDRESS / PHONE NUMBER:_____

4. PREFERRED PHARMACY:_____

LOCATION / PHONE NUMBER:_____

5. PREFERRED LABORATORY:_____

LOCATION / PHONE NUMBER:_____

DENTAL INSURANCE

DENTAL INSURANCE COMPANY NAME:_____

TELEPHONE NUMBER:_____

NAME OF POLICY HOLDER/SUBSCRIBER:_____

POLICY HOLDER EMPLOYER:_____

POLICY OR ID NUMBER: _____

GROUP NUMBER: _____

MEDICAL INSURANCE

MEDICAL INSURANCE COMPANY NAME:_____

TELEPHONE NUMBER:_____

NAME OF POLICY HOLDER/SUBSCRIBER:_____

POLICY HOLDER EMPLOYER:_____

POLICY OR ID NUMBER: _____

GROUP NUMBER: _____

Wood & Myers
Oral & Maxillofacial Surgeons

PATIENT NAME: _____

MEDICAL HISTORY

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

HEIGHT _____ _____

WEIGHT_____ _____

CARDIOVASCULAR SYSTEM

Y	N		Y	N	
☐	☐	ARE YOU CURRENTLY UNDER THE CARE OF A CARDIOLOGIST? *IF YES, NAME OF CARDIOLOGY PRACTICE:*	☐	☐	HEART PALPITATIONS OR FLUTTER
			☐	☐	HIGH BLOOD PRESSURE
			☐	☐	RHEUMATIC FEVER
			☐	☐	OTHER HEART OR VESSEL DISEASE *IF YES, PLEASE DESCRIBE:*
☐	☐	MITRAL VALVE PROLAPSE			
☐	☐	CHEST PAIN, ANGINA			
☐	☐	HEART ATTACK OR STROKE			

_____ _____

PULMONARY SYSTEM

Y	N		Y	N	
☐	☐	ASTHMA	☐	☐	PNEUMONIA (PAST 3 MONTHS)
☐	☐	BRONCHITIS (PAST 3 MONTHS)	☐	☐	PRODUCTIVE COUGH
☐	☐	CHRONIC OBSTRUCTIVE LUNG DISEASE	☐	☐	NASAL CONGESTION
☐	☐	EMPHYSEMA	☐	☐	NOSE BLEEDS
☐	☐	SHORTNESS OF BREATH	☐	☐	SMOKING / TOBACCO PRODUCTS *IF YES, FOR HOW LONG:*
☐	☐	SLEEP APNEA			

_____

WOMEN

Y	N		Y	N	
☐	☐	ARE YOU PREGNANT OR PLANNING PREGNANCY?	☐	☐	ARE YOU NURSING?

GASTROINTESTINAL

Y	N		Y	N	
☐	☐	GASTROESOPHAGEAL REFLUX DISEASE	☐	☐	IRRITABLE BOWEL SYNDROME
☐	☐	COLITIS	☐	☐	OTHER *IF YES, PLEASE DESCRIBE:*
☐	☐	CROHN'S DISEASE			

_____

Wood & Myers
Oral & Maxillofacial Surgeons

PATIENT NAME: _____

OTHER

Y	N	
☐	☐	ANEMIA
☐	☐	JAUNDICE
☐	☐	HEPATITIS
☐	☐	MONONUCLEOSIS (MONO)
☐	☐	DIABETES
☐	☐	THYROID DISEASE
☐	☐	SEIZURES / EPILEPSY / CONVULSIONS
☐	☐	GLAUCOMA
☐	☐	FAINTING EPISODES
☐	☐	BLEEDING PROBLEMS
☐	☐	VENEREAL OR AIDS DIAGNOSIS
☐	☐	BLOOD TRANSFUSION
☐	☐	TUBERCULOSIS
☐	☐	EMOTIONAL / MENTAL HEALTH PROBLEMS
☐	☐	MOTION SICKNESS
☐	☐	KIDNEY DISEASE
☐	☐	SICKLE CELL DISEASE
☐	☐	MUSCULAR DISEASE
☐	☐	PARKINSON'S DISEASE
☐	☐	WEAR CONTACT LENSES / GLASSES
☐	☐	TMJ
☐	☐	SURGICAL JOINT REPLACEMENTS
☐	☐	OSTEOPOROSIS / OSTEOPENIA
☐	☐	IS THERE ANYTHING LOOSE OR REMOVEABLE IN YOUR MOUTH I.E. LOOSE TOOTH, DENTURES, RETAINERS, TONGUE JEWELRY, ETC?
☐	☐	HAVE YOU HAD A CONCUSSION IN THE PAST YEAR? *IF YES, DATE AND MEDICAL ISSUES/RESTRICTIONS:*

_____

Y	N	
☐	☐	ARE YOU PRESENTLY UNDER A DOCTOR'S CARE FOR ANY REASON? *IF YES, PLEASE DESCRIBE:*
☐	☐	HAVE YOU OR A BLOOD RELATIVE HAD SERIOUS COMPLICATIONS WITH GENERAL ANESTHESIA? *IF YES, PLEASE DESCRIBE:*
☐	☐	HAVE YOU HAD A PROBLEM WITH LOCAL ANESTHESIA? *IF YES, PLEASE DESCRIBE:*
☐	☐	DO YOU USE ALCOHOL? *IF YES, HOW MUCH:*
☐	☐	DO YOU USE MARIJUANA AND/OR RECREATIONAL DRUGS? *IF YES, HOW MUCH:*
☐	☐	HAVE YOU HAD RADIATION TREATMENTS? *IF YES, PLEASE DESCRIBE DATE, AREA AND AMOUNT OF RADIATION:*
☐	☐	DO YOU HAVE ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE
☐	☐	ARE YOU TAKING ANY MEDICATIONS FOR DIABETES OR WEIGHT LOSS SUCH AS TRULICITY, OZEMPIC, SEMAGLUTIDE, VICTOZA, PHENTERMINE OR OTHER MEDICATION?
☐	☐	ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BONE DENSITY MEDS OR BISPHOSPHONATES SUCH AS FOSAMAX, ACTONEL, IV-ZOMETA, AREDIA, XGEVA, PROLIA, OR RECLAST THE PAST 12
☐	☐	HAS A PHYSICIAN OR PREVIOUS DENTIST RECOMMENDED THAT YOU TAKE ANTIBIOTICS PRIOR TO YOUR DENTAL *IF YES, FOR WHAT REASON:*
☐	☐	IS THERE ANY OTHER CONDITION NOT LISTED ON THIS FORM THAT YOU FEEL WE SHOULD BE MADE AWARE *IF YES, PLEASE DESCRIBE:*

_____

Wood & Myers
Oral & Maxillofacial Surgeons

PATIENT NAME: _____

ALLERGIES

Y	N		Y	N	
☐	☐	ARE YOU ALLERGIC TO LATEX OR RUBBER PRODUCTS?	☐	☐	ARE YOU ALLERGIC TO LOCAL ANESTHETIC OR NUMBING MEDS?
☐	☐	ARE YOU ALLERGIC TO SOY PRODUCTS OR EGGS?	☐	☐	ARE YOU ALLERGIC TO ANY MEDICATIONS? *IF YES, PLEASE LIST:*

_____

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE TAKING BELOW. PLEASE INCLUDE PRESCRIPTION, NON-PRESCRIPTION, HOMEOPATHIC OR HERBAL, INHALERS, INJECTIONS, OR RECREATIONAL DRUGS.

NAME OF MEDICATION	DOSAGE	CONDITION

NOTE: IF YOU ARE USING ORAL CONTRACEPTIVES, IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES. PLEASE CONSULT YOUR PHYSICIAN FOR FURTHER GUIDANCE.

Wood & Myers
Oral & Maxillofacial Surgeons

PATIENT NAME: _____

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DOCTOR, OR ANY OTHER MEMBER OF HIS / HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____

SIGNATURE *DATE*

(COMPLETED BY STAFF ONLY)

_____ _____

SIGNATURE OF PERSON REVIEWING HEALTH HISTORY *DATE*

_____ _____

SIGNATURE OF PERSON REVIEWING HEALTH HISTORY *DATE*

_____ _____

SIGNATURE OF PERSON REVIEWING HEALTH HISTORY *DATE*

Wood & Myers
ORAL AND MAXILLOFACIAL SURGEONS

INSURANCE POLICY

IF YOU HAVE INSURANCE, WE CAN ASSIST YOU IN SUBMITTING YOUR CLAIM. YOUR INSURANCE CLAIM WILL ONLY BE COMPLETED AND SUBMITTED IF WE ARE PROVIDED WITH ALL PERTINENT INSURANCE COMPANY INFORMATION. IT IS YOUR RESPONSIBILITY TO VERIFY THAT YOUR POLICY IS IN EFFECT AT THE TIME YOUR SERVICES ARE RENDERED. YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. WE MAY NOT BE AWARE OF YOUR SPECIFIC INSURANCE PLAN LIMITATIONS WHICH MAY RESULT IN A PAYMENT THAT DIFFERS FROM OUR ESTIMATED OR ACTUAL COST OF TREATMENT SUCH AS:

- MISSING TOOTH CLAUSE
- PROCEDURES WHICH ARE NOT A BENEFIT
- INACCURATE INFORMATION RECEIVED FROM THE PATIENT
- ANNUAL BENEFIT MAXIMUM BEING REACHED
- CHANGES OR TERMINATION OF COVERAGE

FEES RESULTING FROM LIMITS AND EXCLUSIONS ARE THE PATIENT'S RESPONSIBILITY. INSURANCE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL INFORM YOU IF WE ARE PARTICIPATING WITH YOUR INSURANCE PLAN AND WILL HANDLE YOUR CLAIM ACCORDING TO OUR AGREEMENT WITH THE INSURANCE COMPANY. WE FILE INSURANCE CLAIMS AS A COURTESY TO YOU, OUR PATIENT. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED AND NON-COVERED CHARGES, SECONDARY INSURANCES, "USUAL AND CUSTOMARY" CHARGES, ETC., OTHER THAN TO SUPPLY NECESSARY FACTUAL INFORMATION. DEDUCTIBLES AND/OR CO-PAYMENTS ARE REQUIRED TO BE PAID BY YOU AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT. IF PAYMENT IS NOT RECEIVED FROM YOUR INSURANCE COMPANY, THE BALANCE OF THE ACCOUNT BECOMES YOUR RESPONSIBILITY. I HEREBY AUTHORIZE AND AGREE AS FOLLOWS:

- I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- I UNDERSTAND I AM RESPONSIBLE FOR MY ACCOUNT.
- I AUTHORIZE WOOD & MYERS TO ACT AS MY AGENT TO OBTAIN APPROVAL FROM MY INSURANCE COMPANIES.
- I AUTHORIZE PAYMENT DIRECTLY TO WOOD & MYERS AND/OR MY DOCTOR.
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- I UNDERSTAND BENEFIT INFORMATION GIVEN TO ME BY WOOD & MYERS IS NOT A GUARANTEE OF REFUND.
- I UNDERSTAND THAT MY ACCOUNT BALANCE MUST BE PAID REGARDLESS OF MY INSURANCE.

I HAVE READ THE ABOVE FINANCIAL POLICY AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE PAID BY MY INSURANCE. I UNDERSTAND THAT IF MY ACCOUNT IS NOT PAID WITHIN 90 DAYS, IT WILL BE TURNED OVER TO THE CREDIT BUREAU FOR COLLECTION AND A 30% COLLECTION FEE WILL BE ADDED.

_____ _____

SIGNATURE DATE

==========

ATTENTION MEDICARE RECIPIENTS

MEDICARE WILL ONLY PAY FOR SERVICES THAT THEY DETERMINE TO BE REASONABLE AND NECESSARY UNDER SECTION 1862(A)(1) OF THE MEDICARE LAW. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHERWISE BE COVERED, IS "NOT REASONABLE AND NECESSARY" UNDER MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE.

IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

_____ _____

SIGNATURE DATE

Wood & Myers

ORAL AND MAXILLOFACIAL SURGEONS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME:_____SOCIAL SECURITY NUMBER:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT. WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING:

WOOD & MYERS ORAL AND MAXILLOFACIAL SURGERY, P.C.
ATTN: SITE MANAGER/PRIVACY OFFICER
207 SOUTH 32ND STREET, CAMP HILL, PA 17011
(717) 763-1970 PHONE or (717) 975-2891 FAX

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

_____ _____

SIGNATURE DATE

EXAM & TREATMENT PLAN AUTHORIZATION

WHEN NECESSARY, I AUTHORIZE THE DOCTOR AND WOOD & MYERS STAFF TO PERFORM AN ORAL AND MAXILLOFACIAL EXAMINATION FOR THE PURPOSE OF DIAGNOSIS AND TREATMENT PLANNING. I ALSO AUTHORIZE THE TAKING OF ANY X-RAYS DEEMED NECESSARY AS WELL AS CLINICAL PICTURES INCLUDING INTRAORAL AND EXTRAORAL FACIAL PHOTOGRAPHS. I AUTHORIZE THAT ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT MAY NEED TO BE RELEASED TO MY OTHER DOCTORS AND/OR INSURANCE COMPANIES. ADDITIONALLY, I PERMIT MY CONTACT INFORMATION SUCH AS CELL PHONE, HOME PHONE AND EMAIL TO BE USED IN THE COURSE OF TREATMENT FOR APPLICABLE COMMUNICATION. FURTHERMORE, I HEREBY ACKNOWLEDGE THAT THE OFFICE'S NOTICE OF PRIVACY PRACTICES WILL BE MADE AVAILABLE TO ME UPON REQUEST AND IF I HAVE ANY QUESTIONS, I WILL ADDRESS THEM AT MY APPOINTMENT.

_____ _____

SIGNATURE DATE

Wood & Myers
Oral & Maxillofacial Surgeons

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE WITH CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY. WE ARE HAPPY TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME, PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY OR YOUR FINANCIAL RESPONSIBILITY.

INSURANCE: IT IS YOUR RESPONSIBILITY TO KNOW THE LIMITS AND COVERAGES OF YOUR MEDICAL AND/OR DENTAL INSURANCE. PLEASE MAKE SURE YOU BRING YOUR CURRENT MEDICAL AND DENTAL INSURANCE CARDS WITH YOU TO EACH VISIT.

PLEASE BE AWARE THAT SOME OR PERHAPS ALL OF THE SERVICES RENDERED MAY OR MAY NOT BE COVERED BY YOUR INSURANCE POLICY. IT IS UP TO YOU TO CONTACT YOUR INSURANCE COMPANY AND INQUIRE AS TO WHAT BENEFITS YOU HAVE. IT IS IMPOSSIBLE FOR US TO KNOW EVERY ASPECT OF YOUR INSURANCE POLICY, BUT AS A COURTESY TO YOU, WE WILL COORDINATE WITH YOUR INSURANCE COMPANY TO PROVIDE YOU WITH THE MOST ACCURATE TREATMENT ESTIMATES.

REGARDLESS OF ANY INSURANCE STATUS, YOU ARE RESPONSIBLE FOR ANY AND ALL PROFESSIONAL SERVICES RENDERED. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT, AND YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL AND WILL MAKE EVERY EFFORT TO KEEP THE COST OF YOUR CARE AS LOW AS POSSIBLE.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. IF INSURANCE BENEFITS APPLY, THEN PATIENT CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCES ARE DUE AT THE TIME OF SERVICE. IF YOU ARE UNABLE TO COMPLY, THEN A $20.00 BILLING SURCHARGE WILL BE ADDED TO YOUR ACCOUNT. IF YOU HAVE ANY QUESTIONS CONCERNING YOUR TREATMENT ESTIMATE AND/OR FEE FOR SERVICE, IT IS YOUR RESPONSIBILITY TO HAVE THESE QUESTIONS ANSWERED PRIOR TO TREATMENT TO MINIMIZE CONFUSION. ANY BALANCE ON YOUR ACCOUNT IS YOUR RESPONSIBILITY TO PAY, WHETHER OR NOT YOUR INSURANCE COMPANY PAYS ANY PORTION. AFTER 90 DAYS, IF YOUR INSURANCE COMPANY HAS NOT PAID ON THE RECEIVED CLAIM, IT BECOMES THE PATIENT'S RESPONSIBILITY FOR PAYMENT AND FOLLOWING UP WITH THE INSURANCE COMPANY.

IF YOU HAVE OR DO NOT HAVE MEDICAL AND/OR DENTAL INSURANCE, WE EXPECT PAYMENT IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT.

BILLING: PAYMENT FOR YOUR TREATMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE, HOWEVER IF ADDITIONAL SERVICES ARE RENDERED AT THE TIME OF SERVICE OR YOUR INSURANCE COMPANY DOES NOT PAY THE ESTIMATED AMOUNT. YOU WILL RECEIVE A STATEMENT WITH THE AMOUNT DUE. STATEMENTS WILL BE GENERATED EVERY 30 DAYS, AND A $15.00 PENALTY FEE WILL BE CHARGED FOR EACH SUBSEQUENT STATEMENT PRINTED AND MAILED FOR CHARGES APPEARING ON THE FIRST STATEMENT THAT ARE NOT PAID IN FULL.

IF YOUR ACCOUNT BECOMES DELINQUENT AFTER 90 DAYS, WE WILL BEGIN THE COLLECTIONS PROCESS AND WILL ADD A 30% PROCESSING FEE TO YOUR ACCOUNT. IF ANY LEGAL FEES ARE ACCRUED, YOU WILL BE RESPONSIBLE FOR THE FULL BILL.

IF YOUR PERSONAL CHECK IS RETURNED TO US UNPAID FROM YOUR BANK, A $50.00 RETURNED CHECK FEE WILL BE ADDED TO YOUR ACCOUNT, AND WE RESERVE THE RIGHT TO PLACE YOUR ACCOUNT ON A 'CASH ONLY' BASIS

WE MAKE EVERY EFFORT TO RETURN A CREDIT BALANCE ON YOUR ACCOUNT IN A TIMELY MANNER. ONCE YOUR TREATMENT IS COMPLETE AND THE ACCOUNT IS CLOSED, WE WILL ISSUE REFUNDS IN 90 DAYS. PLEASE SPEAK TO OUR BILLING OFFICE FOR QUESTIONS OR CONCERNS

MISSED APPOINTMENTS: BROKEN APPOINTMENTS, SAME-DAY CANCELLATIONS/RESCHEDULED APPOINTMENTS AND LATE ARRIVALS REPRESENT A COST TO US, TO YOU AND TO OTHER PATIENTS WHO COULD HAVE BEEN TREATED IN THE TIME SET ASIDE FOR YOU. WE RESERVE THE RIGHT TO CHARGE A FEE FOR THESE CIRCUMSTANCES AND COLLECT PRE-PAYMENT FOR YOUR TREATMENT IN ORDER TO BE RESCHEDULED WITH OUR PRACTICE. A $100.00 FEE MAY BE CHARGED FOR THE ABOVE OCCURRENCES AND IF REPEATED, WILL RESULT IN DISMISSAL FROM OUR PRACTICE. FOR NEW PATIENTS, A $100.00 FEE WILL BE CHARGED IF THE FIRST APPOINTMENT IS MISSED.

THE SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF FINANCIAL INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE PAYMENT TO WOOD & MYERS, AND/OR MY DOCTOR RENDERING SERVICE AND/OR TREATMENT.

X _____

Signature

X _____

Date