Maine Oral & Maxillofacial Surgery Associates, P.A.
Bruce V. Gallup, DMD Terry Wang, DMD, MD Brian L Gallagher, DMD
211 Mt. Auburn Ave
Auburn ME 04210
(207) 514-7171

Financial Policy/Privacy Practices/Benefits Authorization/Consent

Patient Name: _____

Parent/Guardian Name: _____ Date:_____

Patient, parent or guardian, please place your initials after each checked box, when you have read and fully understand the following statement(s). If you have any questions, please see a staff member.

Financial Policy: Payment for services is due in full at the time services are rendered. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit. Our office requires the use of Social Security Numbers only for account collections and to process any insurance claims on your behalf. All information is kept confidential. We respect your right to NOT provide your Social Security Number; however, if you do not provide your Social Security Number, our Office Policy requires a copy of your Drivers License or payment by "Cash Only," (no checks or credit cards), and the submission of insurance claims may be your responsibility if that is your ID number.

Insured Patients*:* Often we are required to collect a portion of our charges from some insured patients. You will be told if this situation applies to you. We will be happy to process your insurance claim if you provide us with the proper information to complete your claim. You should bring your insurance card or a completed insurance form for each office visit. Your insurance policy is a contract between you, your employer and your insurance company. We are **NOT** a party to that contract. Our relationship is with you, **not** your insurance company.

Divorced parents: We do **not** intercede with separated or divorced parents for payment. When the parents of a minor child are separated or divorced, the parent who brings the child to the office is expected to pay for care at the time services are rendered unless prior arrangements have been made with the Office Manager. Financial responsibility for care of a minor child outlined in divorce or separation agreements is independent of office policy and management.

Acknowledgement Of Receipt Of Notice Of Privacy Practices:

☒ _____ I have read/received a copy of this office's Notice of Privacy Practices.

Office Use Only: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could **not** be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify) _____.

Consent To Release Medical Information to Payors:

☒ _____ I authorize the release of any medical information necessary to process my insurance claims. In addition, I authorize direct payment to Maine Oral & Maxillofacial Surgery Associates, P.A., for any medical or dental benefits unpaid for services provided by them. I understand that any estimate given by employees of Maine Oral & Maxillofacial Surgery Associates, P.A., does not guarantee payments from insurance companies. Therefore, I understand that I am responsible for any unpaid balance.

(OVER→)

To Our Medicaid/MaineCare Patients: This office participates in Medicaid/MaineCare. Some procedures are **not** covered under the State Of Maine Medicaid/MaineCare Program.

☐ _____ The staff at Maine Oral & Maxillofacial Surgery Associates, P.A., will notify me that, in my case, Medicaid/MaineCare is likely to **deny** payment for services provided. **If Medicaid/MaineCare denies payment, I agree to be personally and fully responsible for payment of all office charges for my care.**

To Our Medicare Patients: This office **DOES NOT PARTICIPATE with MEDICARE,** this office will not bill to medicare and the patient will be unable to submit this claim either.

☐ _____ If I continue with my treatment at Maine Oral & Maxillofacial Surgery Associates, P.A., **I agree to be personally and fully responsible for payment of all office charges for my care.**

To Our Managed Care Patients: As a member of a Managed Care Plan, you should be aware that such plans usually require your Primary Care Provider and/or Managed Care Insurance Company to provide **prior referral authorization** for specialist visits. Please take a moment to review the situations described below **and initial & place** a checkmark by the paragraph that best describes your understanding of the requirements of your plan:

☐ _____ I did **not** obtain prior authorization from my Primary Care Provider and/or Managed Care Insurance Company and am knowingly self-referring for this visit. **I understand that I will be responsible for all charges resulting from this visit.**

☐ _____ I did **not** obtain prior referral authorization from my Primary Care Provider and/or Managed care Insurance Company because I did **not** believe it was required. Or my Primary Care Provider and/or Managed Care Insurance Company informed me that a referral was **not** required. **I understand that I will be responsible for all charges resulting from this visit.**

☐ _____ My Primary Care Provider and/or Managed Care Insurance Company have agreed to refer me for this visit and it appears Maine Oral & Maxillofacial Surgery Associates, P.A. has **not** yet received the appropriate referral authorization. I understand that it is my responsibility to contact my Primary Care Provider and/or Managed Care Insurance Company immediately to confirm this referral and to obtain the authorization number for this visit. If a referral authorization number is **not** confirmed prior to consultation and/or treatment, **I understand that I will be responsible for all charges resulting from this visit.**

☐ _____ Maine Oral & Maxillofacial Surgery Associates, P.A. **has received the proper authorization** from my Primary Care Provider and/or Managed Care Insurance Company.
_____ **(Staff Member's Initials)**

I have read and understand the above statements completely.

_____
Patient/Guarantor's Signature & Date

Office Use Only:

_____
Staff Member's Initials (Reviewed by) & Date