ORAL AND MAXILLOFACIAL SURGERY
AND IMPLANT SPECIALISTS OF MIDDLESEX

Michael K. Goulston, DMD, MD
Diplomate, American Board of Oral and Maxillofacial Surgery

Missed Appointments- Late Cancellations

When you schedule an appointment with us we reserve this time exclusively for your care. We do our best to confirm your appointment, however it is your responsibility to keep this scheduled time. A substantial fee will be charged for missed appointments or late cancellations. **We require 48 hours notice for all cancellations.**

Notice of Privacy Practices Acknowledgment
Release of Medical/Dental Information-Assignment of Benefits

I have reviewed a copy of *Oral and Maxillofacial Surgery and Implant Specialists of Middlesex Notice of Privacy Practices.* I agree and authorize the release of pertinent information to the insurance company, adjustor or attorney involved in my case. I permit this office to initiate a complaint, if necessary, to the insurance commissioner on my behalf. I hereby authorize payment for services directly to *Oral and Maxillofacial Surgery and Implant Specialists of Middlesex. I further authorize that the signature below can be utilized as a "signature on file" for the sole purpose of submission of insurance on my behalf.*

Financial Policy and Patient Payment Agreement

If you have dental/medical insurance and our office participates, we will accept assignment from your insurance company for any covered treatment. **We require payment in full for any uncovered portion (co-payment/deductible) of your care at the time of your appointment.** An ***estimate*** of the amount due from you will be calculated when the appointment is scheduled.

If you do not have dental/medical insurance or we cannot verify eligibility from your insurance carrier, **payment is due in full at the time of the treatment. We verify benefits as a courtesy only and strongly encourage that you <u>ALSO confirm coverage.</u>**

Our financial relationship is with you, the patient. **You, not your insurance company, are ultimately responsible for the payment of all fees charged.** Cash, check, credit card and Care Credit payments are accepted for those who qualify. Our office policy is **not** to extend payment plans. Patient is responsible for collection fees and any other expenses incurred to collect unpaid accounts.

I have read and understand the above agreements.

Patient Name____ **Date**______________________________

Patient/Guardian Signature if patient is a minor____

213 DURHAM AVENUE, SOUTH PLAINFIELD, NJ 07080
P (908) 222-0040 / F (908) 222-0041

MIDDLESEXOMS.COM