Insurance Policy & Financial Agreement

Patient Name:_____ Today's Date:____/____/____

Medical Insurance

Medical Insurance Co.:_____ Phone #:_____

Medical Insurance Co. Address:_____

ID#:_____ SS#:_____ Group/Plan #:_____

Name of Insured:_____ Date of Birth:____/____/____

Insured Address:_____ City:_____ State:_____ ZIP:_____

Insured Home Phone:_____ Cell#:_____ Work #:_____

Insured Place of Employment:_____ Occupation:_____

Patient Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other _____

Dental Insurance

Dental Insurance Co.:_____ Phone #:_____

Dental Insurance Co. Address:_____

ID#:_____ SS#:_____ Group/Plan #:_____

Name of Insured:_____ Date of Birth:____/____/____

Insured Address:_____ City:_____ State:_____ ZIP:_____

Insured Home Phone:_____ Cell#:_____ Work #:_____

Insured Place of Employment:_____ Occupation:_____

Patient Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other _____

Do you have any additional insurance? Medical ○ Yes ○ No Dental ○ Yes ○ No

Is this a Workman's Compensation? ○ Yes ○ No

If yes, please inform our front desk personnel with this information.

OMS is an independent practice. We will file all insurance claims on your behalf the day of service and insurance predeterminations can be filed upon request. However, the insurance contract is between the patient and the insurance company. If you have any questions regarding your insurance coverage, deductions, or exclusions you should contact your insurance company directly. To obtain fees prior to surgery, please inform us to schedule an appointment for a consultation so that an insurance predetermination can be filed. Any balance after insurance reimbursement is the responsibility of the patient. Typically healthcare providers do not become involved in any dispute of denial or settlement issues. Letters of protection from an attorney do not substitute for a payment plan.

OMS has my permission to obtain or release any insurance information on my behalf to help determine the extent of my medical/dental insurance coverage. I understand that OMS is not responsible for interpreting the extent of my insurance coverage nor for any possible misinterpretation by the insurance carrier in determining benefits.

I certify that the above information is complete and accurate.

The guarantor is responsible for all fees, regardless of insurance coverage. I understand that I am fully responsible for all fees,including any amount not covered by insurance. Parents who bring in children and sign as the responsible party will be held responsible for the fees. Balance due 90 days from date of service.

X_____ ____/____/____

Signature of Person Financially Responsible for Patient (Patient, Parent or Guardian) Date

X_____

Printed Name

Robert K. Conlon DDS Kurt E. Bruksch DDS Adam M. Ozment DDS John J. Richard DDS Bryan J. VanOven DDS
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