Mid-Hudson Oral & Maxillofacial Surgeons, PC
29 Fox Str, 3rd Fl , Poughkeepsie, New York 12601
Office- (845) 471-5202 Fax- (845) 471-2092

Financial Policy-Our office policy is payment is expected at time of service for all treatment. We offer the following methods of payment for your convenience; please check the option preferred
____ Cash ____Personal of Business Check _____ Visa, MasterCard & American Express.
The estimate for your treatment is $_________________

The estimate is based upon information provided by you or the person in charge of making your appointment. Any additional x-rays, anesthesia request changes or additional surgical procedures are not included in this estimate.

____***Please check here if you would like to speak with someone regarding the office policy.***

Insurance/ Responsible Party

Name of Employee__________________ ID#/ SS#_______-_____-_____
Birthdate: ___/___/____ Address if different from patient: _______________________
Telephone ( )_____-________Cell Phone ( ) ___-_____ Work ( ) ____-_____
Employer Name & Address:____
Dental Insurance Co. Name & Address____
Group #___________________ Policy #____
Medical Insurance Co. Name & Address_______________________________________
Group #___________________ Policy#____
**please present copies of all insurance cards

I authorize Mid Hudson Oral Surgeons to release any information and bill any third party payers for me/and/or spouse/ and/or children for services rendered. I understand that my insurance may not cover any or all services rendered.

____
Signature Date

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, your will consent to our use & 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 uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of Our Privacy Notice is available at the front desk or upon request. We encourage you to read it carefully before signing this consent.
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that any revocation of this consent will not effect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

____
Signature Relationship to patient Date

Please list names of anyone we can discuss your treatment / billing with.

________________________________ ________________________________

________________________________ ________________________________

*******IF YOU HAVE MEDICARE BENEFITS PLEASE SIGN OTHER SIDE *******

(OVER)