

Craig N Little, DMD

Permission for Treatment

THIS MUST BE SIGNED TO ALLOW FOR AN EXAM AND/OR SURGICAL TREATMENT

I, _____, hereby grant permission to Dr. Little and staff of Summerville Oral Surgery to perform such evaluations and /or treatment as may be deemed necessary or advisable in the diagnosis of my/or minor child's condition. The Medical History form is complete and accurate.

_____ Must be signed by patient or patient's guardian

MEDICAL AUTHORIZATION AND FINANCIAL UNDERSTANDING

In order to control the costs of treatment, your estimated co-pay is expected at the time of service. Please take a moment to read over our office policies and patient responsibilities listed below.

Due to the many changes occurring with the medical and or dental insurances we have no way of guaranteeing benefits available from your specific insurance company. All patients are responsible to contact their insurance company to verify that oral surgery procedures are a covered benefit under your plan. We file all insurances as a courtesy and make every effort to help advise you on benefits available, however, we can not guarantee payment from the insurance company. If we have a participation agreement with your insurance company we will verify coverage and **ESTIMATE** your portion of the service to be paid at the time of surgery.

If we do not have a participation agreement with your medical/dental insurance company or if there is **NO** benefit available then payment is due in full on the date of service. We will submit a claim in the event you are able to get reimbursement. If your insurance company sends payment to our office, a refund will be made to you promptly. If, for any reason, your insurance company issues a check to you that had not been estimated as your portion, we will ask that you sign over the check to our office or write us a check for that amount.

In the event any service is denied by your insurance company for any reason, even after verification of benefits, you will be responsible to pay this balance in full.

If your insurance company does not make payment within 120 days of the date of services were rendered you will be responsible for payment to our office within the next 30 days. A 20% collection fee will be added to your account balance in the event it is turned over to an agency for collection.

I authorize Craig Little DMD to release any necessary information for insurance claims to insurance companies. I permit a copy of this authorization to be used in lieu of the original and request payment of medical and/or dental benefits, either to myself or to Craig N.Little, DMD.

Without valid proof of medical and dental insurance at the time of services all services are payable at the time of your visit. We accept Master Card, Visa, Discover, American Express, Care Credit and cash. We no longer except checks.

If legal action were necessary to collect any unpaid balances, all legal costs incurred in the process would be paid by the patient (guarantor if the patient is a minor).

Name: _____ Date: _____ Signature: _____