RANDOLPH CENTER FOR ORAL & MAXILLOFACIAL SURGERY, P.A.

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Board Certified/Spec. Lic. # 6237
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Board Certified/Spec. Lic. # 2126

OFFICE POLICY

INSURANCE COVERAGE: Since oral surgery can involve dental & medical procedures, we will ask for both dental & medical insurance information. After your treatment we will submit the claim to the appropriate insurance carrier(s) for reimbursement. You are responsible to understand your network benefits, limitations and policies. You may want to check with your benefits office if you have any questions about your coverage. As we cannot guarantee that your insurance company will cover any given procedure, you are responsible for deductibles, co-insurance, co-payments and all non-covered expenses incurred on the day of services rendered.

INSURANCE PROCESS: You are responsible for co-payment, co-insurance and any non-covered expenses. With out of network or traditional insurance we require 20% of our fee at the time of the visit which is applied to your account. Exam fees are due up front and submitted to insurance if applicable. We supply the insurance companies with all codes, x-rays and pathology reports pertaining to your submitted claim within the privacy guidelines of HIPAA. Insurance companies have 30 days by Federal law to pay or deny any claim.

HIPAA: (Health Insurance Portability & Accountability Act) Our staff is HIPAA compliant to safeguard the privacy of all our patient's healthcare information. A copy of the Notice of Privacy Practices is provided to you and is on display in the office waiting area.

SIGNATURE ON FILE / AUTHORIZATION OF BENEFITS

1. I authorize the doctor to act as my agent in helping me obtain reimbursement from my health insurance company, and authorize the use of this form to allow Doctor's office to send written complaint to the insurance commissioner on my behalf, should the claim be delayed beyond 30 days.
2. I authorize the use of this form to serve as notice to permit my insurance company to send payments directly to Randolph Center for Oral & Maxillofacial Surgery, PA, unless otherwise stated on the form.
3. I authorize the Randolph Center For Oral & Maxillofacial Surgery, PA to furnish my insurance company with information about my treatment to be used exclusively for the purpose of obtaining my insurance benefits.
4. I understand that I am responsible for my bill. I also understand that a 1½% monthly (18% annual) late charge will be applied to any overdue unpaid balances after 45 days. I also understand that should my account need to be turned over to a collection agency, a 20% collection fee will be added on.
5. I understand and agree to the terms stated above by my signature below.

SIGNATURE OF PATIENT OR RESPONSIBLE ADULT (18 years and up)

PRINT: _____

Signature _____ **Date** _____

Thank you

Copy Available Upon Request

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☐ 447 ROUTE 10 EAST, SUITE 5 · RANDOLPH, NEW JERSEY 07869 · (973) 328-1555 · FAX (973) 328-3405
☐ 230 ROUTE 206, BLDG. 1, SUITE 105 · FLANDERS, NEW JERSEY 07836 · (973) 598-8423 · FAX (973) 598-8427
☐ 63 NEWTON-SPARTA ROAD, SUITE 201 · NEWTON, NEW JERSEY 07860 · (973) 383-0700 · FAX (973) 383-0707
☐ 616 WILLOW GROVE ST., SUITE 4 · HACKETTSTOWN, NEW JERSEY 07840 · (908) 813-9500 · FAX (908) 813-9547
☐ 35 BEAVERSON BOULEVARD· BUILDING 10, SUITE A · BRICK, NJ 08723 · (732) 920-8800 · FAX (732) 920-8861
WWW.RANDOLPHORALSURGERY.COM

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This acknowledgment

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

For Office Use Only

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

- ❑ Individual Refused to sign.
- ❑ Communications barriers prohibited us from obtaining the acknowledgment.
- ❑ An emergency situation prevented us from obtaining acknowledgment.
- ❑ Other (Please specify)

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