



ORAL AND FACIAL SURGERY ASSOCIATES  
Diplomates in American Board of Oral and Maxillofacial Surgery

## PAYMENT AUTHORIZATION

I, the undersigned, hereby authorize payment directly to Oral Surgery Associates, of medical/surgical/dental benefits, if any, otherwise, payable to me under the terms of my insurance policy.

I fully understand that I am primarily and financially responsible for fees incurred. I further understand that payment to Oral Surgery Associates is not contingent of any settlement judgment or verdict by which the patient may eventually recover said medical/surgical/dental fees.

I hereby agree that I, the undersigned, shall be liable for any reasonable attorney's fees and/or collection costs incurred by Oral Surgery Associates in the event that such medical/surgical/dental bills are placed with an attorney or third party.

I hereby authorize all licensed Oral Surgeons, to release all financial, medical, and other information to my insurance company or my representative, including any attorney of record, with respect to all illnesses or accidents, and medical histories.

I hereby authorize any physician, health care practitioner, dentist, hospital or medical care facility to provide all information on the patient's history to Oral Surgery Associates.

I hereby authorize photocopies of this form to be valid and original.

I am fully aware of the contents of this form and I am signing and agree to the credit policy of Oral Surgery Associates.

RESPONSIBLE PERSON \_\_\_\_\_

PATIENT /PARENT \_\_\_\_\_ DATE \_\_\_\_\_  
*Signature*

PATIENT \_\_\_\_\_ S.S. # \_\_\_\_\_