Center for Oral & Facial Surgery

PATIENT INSURANCE INFORMATION

Welcome to our office. Please provide us with the information requested below. All information is kept confidential.

Patient's Name:_____ Today's Date_____

Sex: _____ Age:_____ Birth Date: _____ Soc. Sec. # _____

Address:_____ Email: _____

City: _____ State:_____ Zip: _____

Home Phone:_____Cell Phone: _____

Responsible/Insured Party's Name (if not already given): _____

Medical Insurance Plan: _____

Medical Insurance Number:_____ Group Number:_____

Medical Claims Address: _____

ATTENTION: WE ARE OUT OF NETWORK WITH ALL MEDICAL PLANS. PLEASE FORWARD ALL PAYMENTS AND EOBS RECEIVED FROM YOUR MEDICAL INSURANCE TO OUR OFFICE

Fees & Payment

We file with your insurance company as a courtesy to you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Our relationship is with you, to provide quality healthcare to you and/or your dependent. Consequently, all
Charges incurred are your responsibility. The obligation to ensure payment in a timely manner lies with you**. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE, COINSURANCE, AS WELL AS ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY**. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I hereby assign and request that payment of all medical benefits be made to Torin W. Rutner, DMD, MD. I understand that I am financially responsible for any and all charges incurred while under the care of Dr. Rutner

Signature _____Date _____

___Covid Nasal Swab Z03.818 C455

___Covid Antibody Blood Draw U07.1 C480