Cherry Orchard
ORAL & IMPLANT SURGERY

Insurance Agreement

(Please Initial)

_____ I understand that Cherry Orchard Oral & Implant Surgery will help file my insurance as a courtesy. It is ultimately my responsibility for payment on the balance of this account.

_____ ****BE ADVISED- If your dental coverage is through United Healthcare, we WILL NOT FILE A CLAIM ON YOUR BEHALF if the treatment is extensive in nature or involves wisdom teeth extractions. The patient will be expected to file their own claim. We will provide paper copies of relevant x-rays and surgical notes for the patient to do so. After these are provided to the patient, Cherry Orchard Oral Surgery will have no further involvement in the processing of these claims and the onus will be entirely upon the patient. ***

Cancellation Policy

(Please Initial)

_____ I understand that if my appointment has to be cancelled or changed for any reason it must be done within 24 hours. If I must cancel or reschedule with less than 24-hour notice Cherry Orchard Oral & Implant Surgery will charge me a cancellation or rescheduling fee of $25.00.

Signature of Responsible Party: _____ Date: _____

Authorization for Release of Information

(Please Initial & Sign)

_____ I have received a copy of the Notice of Privacy Practices for the practice Cherry Orchard Oral & Implant Surgery.

Please Print Name: _____

Signature: _____ Date: _____

Name of Patient (if different from above): _____

_____ I authorize the following individuals to have access to my information (covered in the Notice of Privacy Practices mentioned above):

_____

(Name & Relationship)

_____

(Name & Relationship)

_____

(Name & Relationship)

Brian R. Cherry, DMD *Board Certified Oral and Maxillofacial Surgeon*

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