

MAXILLOFACIAL AND ORAL SURGERY, P.A.

University of Minnesota, Division of Oral and Maxillofacial Surgery

SURGERY ▪ RESEARCH ▪ EDUCATION

Important Authorizations

Please initial each section and sign at the bottom of the page.

Patient name (please print) _____

Financial Policy

My signature below indicates that I have been provided with a copy of the *Financial Policy*.

Assignment of Benefits

I hereby authorize direct payment to Maxillofacial & Oral Surgery, P.A., of any medical benefits otherwise payable to me for services provided by Maxillofacial & Oral Surgery, P.A.

Records Release

I hereby authorize Maxillofacial & Oral Surgery, P.A., to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

Notice of Privacy Practices

My signature below indicates that I have been provided with a copy of the *Notice of Privacy Practices*.

Email or Electronic Communications

My signature below indicates that I understand if I initiate communication to Maxillofacial & Oral Surgery, P.A., via email, fax, or other forms of electronic communication that I am agreeing to receive communication back from Maxillofacial & Oral Surgery, P.A., via email, fax, voice, or other forms of electronic communication.

These forms have been given to me and I have been given an opportunity to ask questions about them.

Signature of patient/client or personal representative

Date

If signed by personal representative, relationship to patient: _____