PAYMENT POLICY

To insure that we understand how you wish your account to be handled, please check the payment methods you prefer and sign on the space indicated. In most cases, you should mark MORE THAN ONE payment method (i.e., check and insurance).

CASH_____CHECK_____CREDIT CARD_____MEDICAL INS_____DENTAL INS_____

SIGNATURE_____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Oxford Maxillofacial Surgery Center (DBA, Dr. Scott Whitaker) of the insurance benefits otherwise payable to me.

SIGNATURE_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Oxford Maxillofacial Surgery Center (DBA, Dr. Scott Whitaker) to release any and all protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our "Notice of Privacy Practice."

ACKNOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICES"

I understand a "Notice of Privacy Practices" is posted in the waiting area. I can obtain a copy at my request.

SIGNATURE_____

PHONE CONSENT

I acknowledge that I give Scott D. Whitaker, D.M.D., M.D., staff, or any out of office persons working for Dr. Scott D. Whitaker, to contact me on any telephone number (including cell phones) that is provided by me and/or guardian of patient.

DATE_____ SIGNATURE _____

State relationship if other than patient_____