



Aesthetic Surgical Arts

Oral and Maxillofacial Surgery

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PATIENT FEE AGREEMENT

I understand that all professional services rendered are charged to and are the responsibility of the patient. Although Aesthetic Surgical Arts/Joseph C. Camarata, M.D., D.M.D. will complete insurance forms to expedite insurance carrier's payments, I understand that I am responsible for all fees incurred, including all charges not covered by the insurance carrier for any reason. If my insurance carrier requires by contract a "co-pay" payment to be made by the patient, I will pay that co-pay payment on the day that service is provided.

I understand that it is my responsibility to complete payment in full for services provided on the day charges are incurred. If, for any reason, my account becomes delinquent for 120 days or more, I authorize and understand that my contact information will be turned over to a collection agency and that I am financially responsible for my outstanding balance and any fees that may be associated with the collection process.

Date: _____ Signature of Patient or Guarantor: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Aesthetic Surgical Arts/Joseph C. Camarata, M.D., D.M.D. to furnish information to my insurance carrier(s) concerning my illness and treatments. I hereby assign to Aesthetic Surgical Arts/Joseph C. Camarata, M.D., D.M.D., all payments for medical services rendered to my dependent or myself. I understand that I am responsible for all charges for services rendered that are not covered by insurance and I will pay such charges according to the Patient Fee Agreement.

Date: _____ Signature of Patient or Guarantor: _____

MEDICAL RECORDS RELEASE

I hereby authorize Aesthetic Surgical Arts/Joseph C. Camarata, M.D., D.M.D. to release any information that may assist in my medical or dental care. This may include medical records such as pathology reports, culture reports, progress notes, e-ray and operative reports. I also give permission for A Aesthetic Surgical Arts/Joseph C. Camarata, M.D., D.M.D. to discuss my treatment with a physician or dentist in the event that it may be deemed necessary to provide me with medical and dental care. This release also includes release of information to physical or occupational therapy and communication with my therapist.

Date: _____ Signature of Patient or Guarantor: _____