Joseph Arcuri II DDS
11 Raymond Ave.
Suite 31
Poughkeepsie, NY 12603
845-452-5805

FINANCIAL POLICY

Our financial policy is payment in full or deposits, are due at the time of service for all treatments. The estimate for treatment is $_______________. We accept Cash-Credit-Checks

PATIENT/PARENT/LEGAL GUARDIAN [if minor]

NAME:____

MAILING ADDRESS:____
____

DATE OF BIRTH:____

SS#:____

EMPLOYER:____

TELEPHONE #S

HOME:____

CELL:____

WORK:____

The signature below signifies that the undersigned acknowledges that the surgical fees charged for services rendered are their responsibility to pay. If a patient/parent/legal guardian has dental and or medical insurance that may cover our services, the undersigned also acknowledges that any portion of the surgical fees not covered by their insurance is wholly their responsibility to pay to this office, their signature below signifies agreement of these terms, and they will remit balances owed within 10 days of receipt of a statement from this office.

____ DATE_________________
SIGNATURE: PATIENT/PARENT/LEGAL GUARDIAN

[OVER]

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use & disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our privacy notice is available at the front desk upon request. We encourage you to read it carefully before signing this consent.
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that any revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

____

Signature **Relationship to Patient** **Date**

PLEASE LIST ANYONE WE CAN DISCUSS YOUR TREATMENT/BILLING WITH BELOW:

_______________ _______________ _______________
Name/phone# **Name/phone#** **Name/phone#**

MEDICARE PRIVATE CONTRACT

By signing this contract I understand and agree that I will not submit [or request that my surgeon submit] a claim to Medicare or its agents for services provided by Joseph Arcuri II D.D.S, even if such services would otherwise be covered.
I agree to be fully responsible through insurance or otherwise for payments of services rendered by Joseph Arcuri II D.D.S., and I understand that no claims will be submitted to Medicare and No Medicare reimbursements will be provided for these services.
I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral & maxillofacial surgeon for services provided.
I understand that Medigap plans do not and other health and medical care insurance plans may elect not to make payments for such services.
I understand that I have a right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payments would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care providers who have opted out.
I understand that Dr. Arcuri is not excluded from participating in the Medicare Program under section 1128 of the Social Security Act or pursuant to any other legal authority.
This contract is in effect and will expire on 3/13/2016

Patient Name________________________________ Date:______________________________

Patient Signature:____________________________ Date:______________________________