FINANCIAL AND INSURANCE AGREEMENT

I hereby accept full financial responsibility for the prompt payment of all medical and/ or dental services rendered to _____, by OMS
(Name of Patient)
Specialists, PLLC (Joseph S. Doctora, D.D.S, M.D). I agree to pay promptly in full any additional fee, cost, and/ or expenses, including, but not limited to, investigating costs, attorney's fees, court costs, filing fee's, interest, penalties and all other cost and expenses actually incurred by or on behalf of OMS Specialists (Dr. Doctora) in the event services of an attorney and/ or collection agency are utilized for the purpose of collecting any delinquent balance due on this account. I also understand that, as a courtesy to me, OMS specialist will assist me in processing my insurance claim. However, in the event Sixty (60) days has passed from the date of submission of my claim to my insurance carrier and the balance remain unpaid, I agree to immediately pay the balance due on this account to OMS Specialists. I agree to pay interest at the rate of one and one half (1 ½%) percent per month on this account if its remains unpaid for (60) days from the date the insurance was submitted to my insurance carrier. If they do not receive of lose this claim, it will be the responsibility of the patient to process the claim. I understand and accept that procedures and / or services **not covered by my insurance carrier will not be billed to them,** and by signing this, I also agree **I am fully responsible for those charges.**

By signing this agreement, I understand that lumping, bundling, and/ or changing of CDT-4/ CPT diagnostic codes is a method used by insurance carriers to reduce reimbursement. This practice of changing the diagnosis is not accepted by the American Dental Association nor OMS Specialists and will not be allowed to reduce our financial obligations for services.

By signing this statement, I agree to the assignment of benefits to Dr. Joseph S. Doctora for any services performed in the office or in a hospital.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization, to be used in the place of the original

Name:_____ Date:_____
(Signature)

_____
(Please Print)

Co-Signer Agreement

(You must have a co-signer if you are covered under your parent/ guardian's insurance plan)
As a co-signer for,_____, I personally guarantee payment of all medical and dental expenses incurred by this patient at OMS Specialists for products and services rendered by Dr. Joseph S. Doctora. I personally guarantee payment in full of any additional collection fees, cost and expenses including, but not limited to, attorney's fees, court costs, filling, fees, investigative expenses, penalties and all other fees OMS Specialists may incur in the event that the services of any attorney and/ or collection agency are utilized for the purpose of collecting this account.

Name:_____Date:_____
(Signature)

_____
(Please Print)