Stewart & Arango
ORAL, FACIAL & IMPLANT SURGERY

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PAYMENT AUTHORIZATION

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK PRIOR TO INITIALING

___ 1. I, the undersigned, hereby authorize payment to be made directly to Stewart & Arango Oral, Facial & Implant Surgery, of medical/surgical/dental benefits, if any.

___ 2. I fully understand that I am primarily and financially responsible for fees incurred. I further understand that payments to Stewart & Arango Oral, Facial & Implant Surgery are not contingent of any settlement judgement or verdict by which the patient may eventually recover said medical/surgical/dental fees.

___ 3. I hereby agree that I, the undersigned, shall be liable for any reasonable attorney's fees and/or collection costs incurred by Stewart & Arango Oral, Facial & Implant Surgery in the event that such medical/surgical/dental bills are placed with an attorney or third party.

___ 4. I hereby authorize Stewart & Arango Oral, Facial & Implant Surgery to release all financial, medical, and other information to my insurance company or my representative, including any attorney of record, with respect to all illnesses or accidents, and medical history.

___ 5. I hereby authorize any physician, health care practitioner, dentist, hospital or medical care facility to provide all information on the patient's history to Stewart & Arango Oral, Facial & Implant Surgery.

___ 6. I hereby authorize photocopies of this form to be valid and original. I am fully aware of the contents of this form and I am signing and agree to the credit policy of Stewart & Arango Oral, Facial & Implant Surgery.

CONSENT
I certify that I speak, read, and write English and have read and fully understand this consent and have had my questions answered.

RESPONSIBLE PERSON: _____

PATIENT / PARENT: _____ **DATE:** _____
signature

PATIENT: _____ **SSN:** _____