Oral Surgical Associates

Practice Limited to Oral and Maxillofacial Surgery
1547 South Higgins Ave
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(406) 728-6840

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Armando A. Gama D.D.S. Diplomate

Please read and initial each box that applies to you, the responsible party, as you read and understand each condition:

_____I understand that Oral Surgical Associates is not contracted with Medicare, therefore no claims will be submitted to Medicare or Medicare supplement plans.

_____I have insurance coverage (if yes continue to next line, if no skip to last line)

_____I understand that Oral Surgical Associates will bill my insurance as a courtesy to me given that I provide all the correct information including; subscriber name, date of birth, social security number, and/or ID number, Group number, and claims address.

_____I understand that I am responsible for any remaining amount that is not covered by the insurance company.

_____I understand that it is my responsibility to contact my insurance if there are any discrepancies.

_____I do not have any insurance coverage, and will be paying in full for my services.

_____Other_____

Patient Name_____

Signature X_____
(Parent/Legal Guardian name in case of a minor)

Date_____

Our fees for services, including office visits, are based on the level of professional skill required, the complexity of the treatment, as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services. However, a precise estimate in advance may not be possible.