UB OMFS | Oral & Maxillofacial Surgery
UNIVERSITY AT BUFFALO

GENERAL PRACTICE POLICY

AT THE TIME OF SERVICE; failure to provide the following may result in a rescheduled appointment.

- Patient Social Security Number as needed for eligibility verification. You have the right to decline.
- Current Insurance Card along with complete billing information
- Photo ID
- Workers' Compensation or No-fault claims complete policy information and Notice of Case Assembly for Worker's Compensation, when applicable.
- Co-payment/Co-insurance/Deductible

UBOMFS PRIVACY PRACTICES can be found on our website. You will be asked to attest that you have read and understand our Privacy Practices statement. A copy will be provided upon request.

UBOMFS TEACHING PRACTICE NOTICE
UB Oral & Maxillofacial Surgery, Inc. is a teaching practice. As part of your care, you may be seen by a Chief Resident, Resident and or Intern under the supervision of UBOMFS Attending Physician.

UBOMFS NONDISCRIMINATION
UB Oral & Maxillofacial Surgery, Inc. complies with Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

PROXY
An authorized representative form is available if you wish to designate another person to sign practice documents on your behalf. If you have any questions, please discuss it with UBOMFS staff.

AUTHORIZATION FOR MEDICAL TREATMENT
UB Oral & Maxillofacial Surgery, Inc., physicians, professionals and other personnel are hereby authorized to administer any medical, diagnostic testing, and x-rays (CBCT/Pan X-rays) as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize any insurance carrier with whom I have a policy or claim to pay directly to the UBOMFS provider(s) who have rendered services to me. I agree to pay all charges deemed by the assigned insurance as patient responsibility.

DISCLOSURE OF INFORMATION
I understand that my medical records and billing information are made and retained by UBOMFS and are accessible to office personnel. UBOMFS staff may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my care. Safeguards are in place to discourage improper access.

REQUEST FOR MEDICAL RECORDS
We will respond to your request within 30 days. There is a fee to cover the cost of supplies and postage.

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New York State law allows healthcare providers to charge a "reasonable "fee of 75 cents per page. UBOMFS may also charge for the cost of reproduction of X-rays or diagnostic films and for postage. UBOMFS requires a completed and signed HIPAA-compliant Authorization for Release of Health Information form. Approved by New York State Department of Health, to release your records. Request this form in person, or by calling our office.

REQUEST FORMS COMPLETION
There is a $15 fee for each form a patient requests our office to complete. Payment is due at the time of request. Allow 10 business days to be processed.

USE OF CELL PHONES OR ANY AUDIO OR VIDEO RECORDERS IS STRICTLY PROHIBITED in our office during any encounter with our physicians and staff. Please note the Acceptable Use Mobile Devices are in the waiting areas only.

DISCHARGE FROM PRACTICE
- Violation of any UBOMFS policy, including but not limited to, the policies contained in this packet.
- Failure to keep scheduled appointments
- Behavior that is threatening to physicians, and/or staff or breaches the doctor-patient relationship.

Including, but not limited to, behavior determined to be unpleasant, abusive, disruptive, illegal, confrontational or non-compliant with medical advice.
- Non-payment

It is UBOMFS group policy that if you are discharged from any UBOMFS provider, you will not be permitted to schedule future appointments with any provider affiliated with UBOMFS.

I have read and understand the above policies, and I agree to accept the terms and responsibility for any financial obligations incurred. Additionally, I accept responsibility to notify UBOMFS of any changes to the information I have provided, including, but not limited to, Medical History, Insurance or Patient information.

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Patient Signature Date

Patients with Medicare Benefits
MEDICARE BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE
I request that payment of authorized Medicare benefits be made either to me or on my behalf to UB Oral & Maxillofacial Surgery, Inc., for any services provided to me by UB Oral & Maxillofacial Surgery, Inc. I authorize any holder of medical information about me be released to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

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Patient Signature Date

REV. 3/2026