OMSS
ORAL AND MAXILLOFACIAL
SURGICAL SPECIALISTS, P.C.

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TENNCARE WAIVER OF LIABILITY

I, _____, have been made aware that my insurance may not cover the following services and that I am responsible for all charges incurred relating to these services:

- Cone Beam CT
- Radiology Reports
- CT Conversion fee
- Cardiac Monitor
- Facial Ice Pack
- Procedures denied on Prior Authorization
    - Extraction
    - General Anesthesia
    - Alveoloplasty
    - Operculectomy
- _____ (other)

I have been given an itemization of my proposed treatment plan; therefore, I acknowledge and recognize my responsibility for these charges.

I have chosen **not** to wait on the predetermination process required by my insurance (DentaQuest) and/or accept my responsibility due to denial of the treatment plan Prior Authorization.

I assume the responsibility for deductibles, coinsurance or other fees remaining after processing of my primary insurance plan(s) if applicable. I further acknowledge the amount collected is an estimate of my liability and assume responsibility for any amounts not paid by my insurance plan(s).

Patient estimate: _____

_____ _____
Patient (Guardian if Minor) Date

_____ _____
Witness Date