

Oral Surgery Acknowledgement of Independent Contractor Status

Patient Name _____

Chart Number _____

Date _____

This document is to advise you that your Oral Surgeon is not an employee or agent of this office. Your signature below acknowledges that you understand and agree that your Oral Surgeon is an independent contractor. It further acknowledges that you understand that services received from your Oral Surgeon may be received at any facility and that Dental Group will not be responsible for the actions of or the services provided by your Oral Surgeon. All billing or other services performed on behalf of the Oral Surgeon are done as an accommodation.

ACKNOWLEDGED AND AGREED

Patient Full Name (Print) _____

Patient Signature _____

Witness Name (Print) _____