Insurance

I authorize release of information to all my insurance carriers.

I understand that I am responsible for any part of my bill not covered by my insurance.

I understand that I will be billed for treatment not paid by my insurance 60 days after claim submission.

I authorize payment directly to my doctor.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance.

Consent for Services

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon each diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required providing proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Acknowledgement of Receipt of Privacy Practices and HIPPA Statement

I have received a copy of the Notice of Privacy and a copy of the HIPPA statement for the above named practice.

We reserve, on our schedule, the necessary time for you to receive your recommended treatment. We ask that you please give us at least 24 hours notice of any cancellation of an appointment or there will be up to a $50.00 cancellation fee.

Patient/Parent/Guardian Signature____________________________________ Date____________