CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Insurance Company: _____

ID Number: _____

Group Number: _____

Subscriber Name and Date of Birth: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

FINANCIAL RESPONSIBILITY/HIPPA

I understand that I may be charged 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models and photographs to make a complete diagnosis of my dental needs.

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____

Patient's Signature Date