AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the doctors and/or his staff to disclose specific health and dental information regarding:

____
(Name of Patient)

To:____

____

____

For the purpose of scheduling, diagnosing, and resolution of the account and treatment.
By initialing the spaces below, I specifically authorize the release of the followig information:

______ Diagnosis of treatment

______ Account resolutions

______ Scheduling appointments

I have reviewed and I aunderstand this authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law

Signature:________________________________

Date: ________________

ACKNOWLEDGEMENT OT RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

____
(Name of Patient)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowlegement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

______ Individual refused to sign

______ Communication barriers prohibited obtaining the acknowledgement.

______ An emergency situation prevented us from obtaining acknowledgment.

______ Other (Please Specify)

Authorization and Release

I authorize the dentist or staff to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Collection Fee Policy

If it is necessary to refer this account for collection buyer agrees to pay seller reasonable attorney's fees and collection costs including any collection fees charged by a collection agency. Even though no suit or action is filed. If a suit or an action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action including any appeal therin, is tried, heard, or decided. A finance charge of 9% annual interest will be charged monthly on any account balance over 90 days. For any payment plan over 90 days 9% annual interest on the payment plan total from the start of the payments

Signature: ____ Date:__________________