Authorization

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information I have provided.

I authorize the disclosure of my records (or my child's) to the following persons who are involved in my care (or my child's) or payment for that care, and my consent to disclosure of records shall be effective until I revoke it in writing.

Name of person(s):

Signature of Patient/Legal Guardian:

_____

Date: _____