Anderson Dental

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HIPPA/FINANCIAL POLICY/PATIENT RELEASE

*** ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I acknowledge that the notice of privacy practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the Notice and one will be provided to me.

Initial of Patient/Legal guardian: _____

FOR OFFICE USE ONLY

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

_____

*** FINANCIAL RESPONSIBILITY:** I understand I am personally responsible for any fees I incur for services rendered. I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at the time of service. I acknowledge any demographic information provided by me, including my cellular phone number, may be used to contact me for any purpose, including collection efforts. **I authorize payment for services rendered to be paid by any third party: including, but not limited to, insurance carriers directly to Anderson Dental.**

Initial of Patient/Legal guardian: _____

*** AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the release of my Protected Health Information acquired in the course of my examination or treatment via electronic transition, including emails, to my insurance company to secure payment for services or to other dental providers (specialists) required to participate in my care.

Initial of Patient/Legal guardian: _____

I further authorize the below-named individuals to have access to my personal health information and do acknowledge any party providing insurance coverage or financial responsibility will have access.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of patient/Legal Guardian: _____ Date: _____

Print Name: _____

Witness: _____