DOWNTOWN DENTAL CARE

AUTHORIZATION & DISCOLSURE (HIPPA)
ASSIGNMENT OF INSURANCE BENEFITS
AUTHORIZATION TO RELEASE INFORMATION
FINANCIAL RESPONSIBLITITY

Truth-in lending: In accordance with the Federal Truth-in Lending act, we are providing the following information about our credit and fee policy.

1. Patient portion is due at time of service.
2. Balance extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%).
3. There will be a 25.00 fee charged for all returned checks.

Initial_____ Assignment of Insurance Benefits: I hereby authorize Downtown Dental Care to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Downtown Dental Care. I authorize Downtown Dental Care to transfer records when necessary on my behalf.

Initial_____Authorize to Release Information: 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.

Initial_____Financial Responsibility: I understand that it is my responsibility to provide complete, accurate and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be responsible for the dental services received. I authorize Downtown Dental Care to be able to leave a Detailed message about my account balance, insurance, and past due payments. Phone Number we can leave message: _____

Initial_____Appointment Guidelines and Agreement: Since providing quality treatment for all or our patients in a timely manner is a major focus of our practice philosophy, we ask that you assist us in the endeavor. There will be absolutely no charge for your need to reschedule an appointment provided you give us 48 hours notice and contact us during business hours. This will allow us the opportunity to give this appointment time to another patient who is in need and waiting to be seen. A 50.00 fee per hour will be charged without 48 hours notice. Last minute cancellations can cause hardships for many individuals, especially those patients who are waiting for dental treatment. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

Print Name_____Date_____

Signature_____