Patient Authorization and Release 2005

I authorize the dentist and/or his staff to release any information including the diagnosis and records of such treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or other health practitioners.

I authorize my dental insurance company to pay directly to Hunting Hills Family Dentistry insurance benefits otherwise payable to me.

I understand that Hunting Hills Family Dentistry is not a participating provider with any insurance company. This office will file your claim and any additional information to all commercial insurance carriers. Any deductible not met for the current year plus estimated copay will be required at each visit. Hunting Hills Family Dentistry has the right to cancel or postpone any appointment if the copay is not paid at the time of service. Because we are non-participating with Delta Dental Insurance Company, and because Delta Delta reimburses the patient directly, all Delta Dental covered patients will be required to pay for each visit in full at the time of service.

I understand that my dental insurance carrier may pay less than the actual total for services and that I am responsible for any amount not paid by the insurance company. A monthly service charge of 1.5% will be added to any account balance over 60 days old.

I understand that if payment is not made when the account is due, the account may be turned over to a collection agency. I will be responsible for any and all costs associated with the collection procedure, including, but not limited to billing costs, finance charges, collection fees, lawyer fees, and court costs.

I understand that if payment is made by check and the check is returned by the bank for non-payment, a returned check fee of $25.00 will be added to my account.

Our office understands that situations arise in everyone's schedule to cause a cancellation. Our office requires a 48 hour notice for cancellations, however we normally do not charge for the first occurrence of a cancellation. At our discretion, repeat broken appointments or cancellations without proper notice may be subject to a $50.00 broken appointment fee.

X____

Signature of patient or parent if patient is a minor　　　　Date

** Please understand that refusal to sign this consent and authorization means that you will be responsible for total charges on the day services are rendered whether insured or not. Our office would then file all charges to insurance for the patient, and will have insurance reimburse the subscriber directly.

Rev. 12/04