CERTIFICATION OF MEDICAL INFORMATION

I certify that I have read and understand all health questions given to me to the best of my knowledge. All health questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and for health practitioners.

AUTHORIZATION FOR INSURANCE TO PAY PROVIDER DIRECT

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, otherwise payable to me. I understand that any dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on any behalf or my dependents.

PROFESSIONAL FEES AND PATIENT RESPONSIBILITY

1. I understand that substantial time is reserved for each treatment session and that additional charges *may* be applied for tardiness, broken appointments, or cancelled appointments without at least 48-hour notice.
2. I understand that occasionally a tooth which has received dental treatment will require further treatment and if necessary any additional fee may be charged.
3. I understand that if my account should be turned over for legal collection, I agree to pay for all cost of collection including postage, court costs, and attorney fees.
4. I understand the treatment plan when presented is only an estimate based off of the information provided to us by your insurance company. I also understand that if for any reason insurance doesn't pay the amount that is estimated, I am fully responsible for any balance due within 30 days.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES HIPAA

HIPAA Privacy Practices: We will not release any of your information to anyone (family member, spouse, Physician, Dental Office etc…) unless an authorization of release has been signed.

I, _____, acknowledge the HIPAA Privacy Practices and agree. (A copy of the HIPAA Privacy Practices will be provided by Wauchula Dental upon request).

List Name of authorized person to receive information in reference to your dental treatment, appointments etc.

Name: _____ Relationship to Patient: _____

By signing below, I as the patient, parent or legal guardian agree to and acknowledge the information pertaining to **CERTIFICATION OF MEDICAL INFORMATION and INSURANCE, PROFESSIONAL FEES AND PATIENT RESPONSIBILITY and HIPAA (Privacy Practices).**

Print Name of Patient _____

Print Name of Parent or Guardian_____

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date