Authorization To Share Medical Information

Your Right to Medical Information Confidentiality Under HIPPA

HIPPA (Health Insurance Portability and Accountability Act of 1996) states if you are 18 years or older, you have the right to strict confidentiality regarding your visits to Wilbraham Dental Associates, LLC. In order to release any information including date or nature of visit, Wilbraham Dental Associates, LLC must have your signed consent and specific directions about what information you are consenting to be released. Without written consent Wilbraham Dental Associates, LLC cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, or other medical professionals. In addition, you have the right to evoke this authorization at any time. Revocation will be effective when Wilbraham Dental Associates, LLC receives written notice that this authorization has terminated. A copy of this document will be kept in your health record.

Patient's name: (please print)_____

Date of Birth: _____/_____/_____

In signing this authorization to release my protected health information I acknowledge that I have read and understand my rights to medical information confidentiality and authorize Wilbraham Dental Associates, LLC to discuss health issues regarding:

_____

_____

_____

With the following listed individuals:

_____Relationship:_____

_____Relationship:_____

Date Authorization Expires:_____

Signature of Patient:_____**Date:**_____

Financial Policy

Thank you for choosing our office for your dental needs. We are committed to providing our patients with the best possible treatment and service. The following statement of our financial policy which *we request that you read, agree and sign prior to any treatment.* A copy of this policy will be given to you if requested.

- Payment is due at the time of service.
- For your convenience we accept Visa, MasterCard, Discover, American Express, CareCredit, personal check, and cash.
- As a courtesy to our patients we also accept assignment of insurance benefits.

Regarding Insurance Assignment

The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance unless you provide all insurance information. Your insurance benefit is a private contract between you and your insurance company and Wilbraham Dental Associates, LLC is not a party to that contract. The estimate provided by the office is a guideline and we appreciate the patient's co-payment at each visit. Claims are submitted promptly after treatment is rendered. You must understand that it is your responsibility to know the policies of your insurance company and that Wilbraham Dental Associates, LLC is not responsible for knowing what your insurance policy will and will not cover.

Missed Appointments

No charge will be made for rescheduling an appointment provided 24 hour notice is given. Please remember that your appointment time has been reserved for you.

Financial Consent

The patient (or guardian) agrees to be fully responsible for total payment of procedures performed at this office, including any treatment not a benefit of any insurance.

I certify that I have read, understand and agree to this policy.

Signature:_____Date:_____

Consent For Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to said Doctor or his assignee at the time services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me in writing within the time for payments thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if such be instituted hereunder.

I grant permission to you or your assignee to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date:_____Relationship to patient_____
Signature of patient, parent, or guardian

_____Date:_____Relationship to patient_____
Signature of guarantor of payment/responsible party

Dental Insurance Information

Name of person carrying primary dental insurance:_____

Date of Birth:_____/_____/_____ Employed by (or Retired from):_____

Employer's Address:_____

Primary Insurance Company:_____ID#/SS#:_____

If you have a second dental insurance policy, please fill out the following:

Name of person carrying secondary insurance:_____

Date of Birth:_____/_____/_____ Employed by (or Retired from):_____

Secondary Insurance Company:_____ID#/SS#:_____