Oaks
DENTAL GROUP

Patient Release/ HIPPA/ Financial Form

Thank you for the confidence you have shown by choosing us to provide for your dental needs. We are pleased to assist with you insurance (if applicable): HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF YOUR BILL.

1. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment of records), via electronic payment for services or to other dental providers required to participate in my care. I further authorize the below named parties to have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ **DATE:** _____

2. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND NOTICE OF MATERIALS:** I acknowledge that the notice of Privacy Practices and Materials Data 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.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ **DATE:** _____

3. **FINANCIAL RESPONSIBILITY:** I understand that I am personally responsible for any fees I incur for the services rendered. I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at the time of service. Finance charges mat be assessed against overdue accounts. I agree to pay ALL costs directly associated with such collection efforts. I acknowledge that I will be charged a fee of $150.00 for a missed or failed appointment with less than 24 hour notice.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ **DATE:** _____