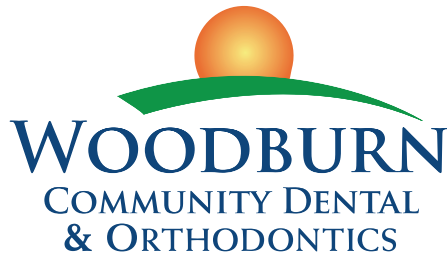

AUTHORIZATION & DISCLOSURE (HIPAA)

Truth-In-Lending Disclosure: 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 the time of service.
2. Balances extended beyond 90 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 may be a fee charged for cancellations with less than 48 hours notice.
4. There may be a fee charged for all returned checks.

Assignment of Insurance Benefits: I hereby authorize Woodburn Community Dental to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Woodburn Community Dental.

Authorization 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.

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 financially responsible for the dental services received.

Authorization to Perform Procedures: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

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 Full Name (Patient or Responsible Person, if patient is a minor) Date of Birth

Signature Date

Authorization valid until specifically revoked in writing.