



INSURANCE ASSIGNMENT & RELEASE

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company PRIOR to any treatment being performed. Please remember your insurance policy is between you and your insurance company.

INITIAL HERE THAT YOU HAVE READ THE ABOVE _____

- I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
 - I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS.
 - I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
 - I AUTHORIZE MY DOCTOR TO ACT AS AN AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS.
 - I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
 - I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
 - I UNDERSTAND THAT EVEN THOUGH THIS OFFICE IS ACTING AS AN AGENT BETWEEN ME AND MY INSURANCE COMPANY, THE INSURANCE POLICY BELONGS TO ME AND I AM RESPONSIBLE FOR WHATEVER THE INSURANCE COMPANY DOES NOT PAY.
 - I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HUDEC DENTAL FINANCIAL POLICY.
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I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Hudec Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Hudec Dental to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I also authorize the use of this signature to furnish all medical records pertaining to treatment of patient.

Name (please print) _____ Date _____

Signature _____

(Parent or Guardian must sign if patient is a minor)

HIPPA Privacy Sheet

I acknowledge that I have received a copy of the HIPPA privacy sheet

Patient Initials