

HUDEC DENTAL ASSOCIATES

Old Brooklyn  
3329 Broadview

Lutheran Atrium  
1730 West 25<sup>th</sup>

Lorain Ave.  
12409 Lorain Ave.

Strongsville Towne Center  
15207 Pearl Rd.

Westpark  
14601 Puritas

Dear Patient:

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.**\_\_\_\_\_

-----SIGNATURE ON FILE FOR INSURANCE-----

\_\_\_\_\_ 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.

NAME (PLEASE PRINT) \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_  
(PARENT OR GUARDIAN MUST SIGN IF PATIENT IS A MINOR)

INSURANCE I.D.# \_\_\_\_\_