<u>Assignment of Benefits</u>

Patient Name_________________________________ Date___________________

I Hereby irrevocably authorize office of Dr. Patricia M. Hartman to apply dental insurance benefits (if applicable, No Fault, Personal injury Protection and Workers Compensation) on my behalf and to take all necessary steps to collect such benefits, including but not limited to filing for arbitration as provided by statutes. I hereby authorize payment of any/all dental benefits and insurance proceeds be made on my behalf to the above. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my dental insurance carrier agents, and any and all other information needed to determine the benefits payable for related service(s).

____ Date____________________

Signature of Patient/Guardian

Acknowledgement of receipt of notice of Privacy Practices

Your personal information may be used by our physician, our office staff and others outside of our office involved in your care, including insurance companies and doctor referrals. We will not disclose any other information without your permission.

By signing below, I hereby acknowledge receipt of Dr. Patricia M. Hartman D.D.S

____ Date___________________

Signature of Patient/Guardian

Release of Information

I hereby authorize Dr. Patricia M. Hartman, D.D.S and/or its designees to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjustor, collection agency or attorney, if applicable in this case.

____ Date___________________

Signature of Patient/Guardian

Consent for a Minor for Dental Treatment

The procedure has been explained in detail and I, as the legal guardian/parent of__________________________ understand it and agree to it. I hereby give my informed consent for____________________________ to be performed.

____ Date_________________

Signature of Patient/Guardian

Financial Policy

If dental insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when your services are rendered. Any services that are not fully reimbursed by your insurance company and are indicated on your insurance's explanation of benefits to be the patient's responsibility will be due and payable upon receipt of billing statement. If documentation is not presented at the time of the service, you are responsible for the full amount of charges incurred. Also, please be aware that this office will collect from patient deductibles, patient co-payments, and patient co-insurance payments due.

If you do not have dental insurance, financial arrangements will be made prior to services rendered. Otherwise, full payment will be expected at the time of services. If your account should become delinquent, and is forwarded to our collection attorney, a 2.5% interest rate will be applied monthly to delinquent balance plus collection cost until the debt is paid in full. If for any reason you are unable to keep your appointment, 24 business hours, Monday through Thursday, advance notice must be given to avoid additional fee.

____ Date___________________

Signature of Patient/Guardian