TETTING & TETTING DENTAL

Authorization for Disclosure of Health Information

Patient Information

Patient's Name:____________________________ Date of Birth:____________

I hereby authorize: Name **TETTING & TETTING**

Street Address **901 W. Association Dr.**

City, State, Zip **Appleton, WI 54914**

To disclose my protected health information or information on appointments to:

Name of individual or Entity____

Name of Individual or Entity____

Name of Individual or Entity____

Purpose of Disclosure

o____

o At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the privacy standards and my health information might be redisclosed without my authorization. I understand that I have a right to:

- **Receive a Copy of this Authorization.**
- **Refuse to Sign this Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke this Authorization,** except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization. This authorization may be revoked in writing by the patient.

This authorization will remain in effect until the following date______________, or event________________________

Signature of Patient (or Legal Representative)________________________ Date___________

Relationship to Patient____Date____________

FINANCIAL INFORMATION

We realize that the highest quality of dental care is not inexpensive, and we have different payment options available to you in order to make your care financially comfortable.

Your estimated portion is expected at the time of service. We will be happy to file your insurance claim and submit any necessary paperwork to the insurance company as a courtesy to you.

For extended payment options, we also offer CARE CREDIT. This option gives you the ability to make affordable payments over an extended period of time.

While insurance is pending you will receive a statement once a month. If your insurance carrier does not make payment within 60 days of claim submission, you are responsible for the entire balance. Balances over 60 days are subject to a monthly 1% late fee.

A fee of $40.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 24 hour notice. Our returned check fee is $45.00.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the past charges on the account. The parent authorizing the treatment for the child will be responsible for all charges incurred.

A parent must accompany minor patients to their first dental appointment. For unaccompanied minors, non-emergency treatment may be denied unless a parent has given our office prior consent to treat the minor patient and made financial arrangements.

If you wish to have your records transferred to another provider, you must complete a record release request form. There is a duplication fee of $15.00 per person for each set of x-rays.

BY SIGNING THIS AGREEMENT, I INDICATE THAT I HAVE READ UNDERSTAND AND AGREE WITH THE POLICY. I AGREE TO PAY FOR ALL SERVICES RENDEREDTO ANY MEMBER OF MY ACCOUNT.

_______________________________ ____________________

Signature Date