DAY & NIGHT
FAMILY DENTAL

1408 Skibo Rd.Fayetteville, NC 28303

PLEASE READ STATEMENTS BELOW, SIGN, AND DATE

AUTHORIZATIONS

I herby request that payment of authorized benefits are made to Day and Night Family Dental for services furnished to me. I understand that any portion unpaid or denied by my insurance company is my responsibility and will be paid by me according to Day and Night Dental Policy. I authorize the release of any information the dental benefits provider may require to determine the benefits payable. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

CREDIT POLICY

I have reviewed a copy of Day and Night Family Dental Credit Policy.

I UNDERSTAND THAT CO-OAYS AND DEDUCTIBLES ARE REQUIRED ON THE DAY OF SERVICE.

Initials_____

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

"You may refuse to Sign This Acknowledgement"

I , _____, have read a copy of this office's HIPAA Notice of Privacy Practices.

Signature_____ Date_____