DAY & NIGHT
FAMILY DENTAL

1408 Skibo Rd, Fayetteville, NC 28303

AUTHORIZATIONS

PLEASE READ THE STATEMENTS BELOW, SIGN, AND DATE

I hereby request that payment of authorized benefits are made to Day and Night Family Dental for services furnished to me or my family members covered under my dental insurance or dental benefit plan. I understand that I am the financially responsible party for any services provided by Day and Night Family Dental but not paid by or denied by my dental insurance or dental benefit plan. 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.

PATIENTS NAME_____

SIGNATURE_____ **DATE**____/_____/_____

CREDIT POLICY

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

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

Initials_____

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I _____have read copy of this office's HIPAA Notice of Privacy Practices

Signature_____ Date_____

Persons/Organizations Authorized to Receive and/or Disclose my Health Information:

Privacy regulations require us to have releases signed by our patients for us to speak with family members

Regarding accounts, insurance, and treatment. Each person must be listed individually by name:

NAME:_____RELATIONSHIP_____

NAME:_____RELATIONSHIP_____

NAME:_____RELATIONSHIP_____

NAME:_____RELATIONSHIP_____