

# **LUSK FAMILY DENTISTRY**

## **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **INSURANCE AUTHORIZATION SIGNATURE ON FILE**

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record. Please sign both authorizations.

**AUTHORIZATION TO RELEASE INFORMATION:** I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signed (patient, parent or legal guardian if minor)

**AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST:** I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I \_\_\_\_\_, am aware that the insurance coverage fees presented to me by Lusk Family Dentistry are only an estimate. All treatment not covered by insurance; I the guarantor will be responsible of the amount unpaid.

Signature \_\_\_\_\_ Date \_\_\_\_\_