

Privacy Practice (HIPPA)

You may refuse to sign this Acknowledgement

(A complete copy of the HIPPA Law is provided in the office Lobby)

By signing below, you understand we cannot release any information without your written consent. However this is not your written consent, just an understanding of the privacy (HIPPA) law.

Patient / Guardian _____

Please Print _____

If Patient is Under 18 Years of Age

Responsible Party: _____ Relation to Patient: _____

Address: _____
Street City State Zipcode

Patient or Parent/Guardian Signature Date

Insurance Information

Primary

Insurance Plan Name and Phone#: _____

Name of Insured: _____ Insured's Birth Date: _____
Last First MI

ID#: _____ Insured Address: _____
If different than patients

Insured Employer Name / Address: _____

Secondary

Insurance Plan Name and Phone#: _____

Name of Insured: _____ Insured's Birth Date: _____
Last First MI

ID#: _____ Insured Address: _____
If different than patients

Insured Employer Name / Address: _____

Consent For Services

- I authorize Dental Specialists of Saginaw and staff to perform diagnostic services and treatment as may be necessary for dental care of myself or my dependents.
- I authorize the release of any information regarding my health history. Treatment, or proposed treatment, by Dr. Elliott to another dentist or insurance company.
- In consideration for the professional services rendered to me, by the doctor, I agree to pay therefore the reasonable value in full of said services of Dental Specialists of Saginaw, at the time said services are rendered. I agree to pay actual cost of collections including any court costs and attorney fees if suit is initiated or a collection agency be utilized.
- I grant my permission to you and your assignee, to telephone me at home or at my work to discuss matters related to this form.
- I have read the above conditions of treatment and agree to their consent.

Signature of Patient, Parent or Guardian Date Relationship to Patient

*This will serve as the responsible party's signature on file for the purpose of administering insurance benefits.