NELSON & PAGE DENTAL, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or been given an opportunity to receive a Notice of Privacy Practices of **Nelson & Page Dental, P.C.** I understand that my Protected Health Information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT AND HEALTHCARE OPERATION of the practice.

PRINTED NAME _____DATE_____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE RELATIONSHIP (IF OTHER THAN SELF)
(REQUIRED IF THE PATIENT IS A MINOR OR AN ADULT WHO IS UNABLE TO SIGN)

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize **Nelson & Page Dental, P.C.** to discuss my Protected Health Information (PHI) with the following person(s). Should I wish to revoke this authorization I understand I must do so in **WRITING**. Any additional authorizations may be added to the back of this sheet.

NAME_____PHONE_____RELATIONSHIP_____

NAME_____PHONE_____RELATIONSHIP_____

PRINTED NAME_____DATE_____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE RELATIONSHIP (IF OTHER THAN SELF)
(REQUIRED IF THE PATIENT IS A MINOR OR AN ADULT WHO IS UNABLE TO SIGN)

This HIPAA form will expire 3 years from the date signed on this form

CONSENT TO ASSIGNMENT OF BENEFITS, ACKNOWLEDGMENT OF RESPONSIBILITY OF MY INSURANCE AND PROMISE TO PAY

I hereby assign all of my right to insurance benefits and instruct my insurance company to make payments directly to **Nelson & Page Dental, P.C.** for the benefits provided.

I acknowledge that the insurance information provided to **Nelson & Page Dental, P.C.** is current and correct and that it is **MY RESPONSIBILITY** to know my benefits, deductibles, maximums and co-pays. I acknowledge that it is a **COURTESY** that this office submits my insurance claims for me. **AS A COURTESY**, the staff of **Nelson & Page Dental, P.C.** will assist me, if possible and if time allows, when any questions arise with my insurance coverage.

PROMISE TO PAY: I agree that I am responsible to pay for all services provided to me by **Nelson & Page Dental, P.C.** and its staff. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay interest thereon at the rate of 1.5% per month (18% annum) and pay all reasonable attorney fees and court costs. I also agree that in the event this agreement is assigned to any agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

PATIENT NAME_____ (IF OTHER THAN SELF)

PRINTED NAME_____ (**OF SIGNING PARTY**)

_____ _____ DATE_____

SIGNATURE OF PATIENT OR REPRESENTATIVE
(REQUIRED IF THE PATIENT IS A MINOR OR AN ADULT WHO IS UNABLE TO SIGN)