Financial Statement and Agreement

I do authorize and give consent to Drs. Albright Smith and Peck and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient. I also give my permission to request and obtain records from any source necessary in the treatment and/or diagnosis for the above named patient.

I understand that I am responsible for all covered and non-covered services performed. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits. I am aware that in the event I or my insurance company does not pay for services rendered that I will be responsible for all collection fees and court costs. Please understand that your insurance is a contract between you and your insurance company. Insurance claims which are denied, rejected or not paid within sixty (60) days will be your personal obligation. Your assistance in seeing that this claim is paid within this time period will be appreciated.

If you do not have insurance coverage you are responsible for all charges for services performed.

Responsible Party Signature _____ Print Name _____ Date _____

DRS. ALBRIGHT, SMITH & PECK
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRICACY PRACTICES FROM DRS. ALBRIGHT, SMITH & PECK

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

AUTHORIZATION TO RELEASE APPOINTMENT/REFERRAL INFORMATION

I herby authorize the physicians and/or staff of Drs. Albright, Smith & Peck to release appointment, referral information, prescription information, etc. as indicated below.

_____ Information may be left on the home or work answering machine.

_____ Information may be shared with the following individuals.

_____

_____

I understand that this authorization will be maintained in my medical record. I have the right to update this authorization at any time by submitting a request in writing signed by me.

I herby give providers of Drs. Albright, Smith & Peck my permission to provide treatment for me as medically necessary.

_____ _____
Signature Date

_____
Witness (office personal)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (please specify)