CHILDREN'S DENTISTRY OF STUART

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize any Provider, Insurance Company, Employer or Organization to release any information regarding the medical, dental, treatment, or benefits payable, including disability or employment related information concerning this claim. I authorize the release of itemized explanation of benefits to the provider of services if he so requests. I authorize the attending dentist to release any information regarding claims during the duration of the policy or contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

______________________ ______________________________

Date Patient or Authorized Person's Signature

Insured Social Security Number: ________________

AUTHORIZATION TO PAY BENEFITS TO THE DENTIST

I hereby authorize payment directly to the dentist providing services of the benefits otherwise payable to me. I agree that a photographic copy of this authorization is as valid as the original.

______________________ ______________________________

Date Employee or Authorized Signature

PATIENT NAME: ______________________________ Date of Birth: ______________

INSURED NAME: ______________________________ Date of Birth: ______________

EMPLOYER: ____

INSURANCE CARRIER: ____

GROUP OR POLICY #: ____

OUR INSURANCE POLICY

Most dental insurance is provided as a benefit through employers or employee groups. Very few plans cover the entire cost of dental treatment. The amount of your coverage depends upon the agreement between your group or employer and the insurance company. The more coverage purchased, the better your benefits will be. We will be happy to work with you to help you receive the maximum benefits provided by your plan. However, there are many different plans available, and we cannot be experts on all of them. Please bring your benefits booklet with you at your next visit, and we will be glad to help you understand your coverage.

Although you may have dental insurance, you are ultimately responsible for payment. If we choose to accept assignment, your insurance company will make payments directly to the doctor. In this case, we will file the claim on your behalf. Please be advised that you are still responsible for your portion of the fee i.e., the deductible plus the estimated co-payment. If the payment we receive from all sources results in an overpayment, we will promptly refund the difference to you. You will be responsible for any amount of the fees not covered by your insurer. This amount will be due upon request.

I (we) understand the above insurance policy.

______________________ ______________________________

Date Patient or Authorized Person's Signature

Reorder 10/13 OBS 1-800-634-1876