

AUTHORIZATION FORM

I understand that my dental insurance is a contract between the insurance carrier and me, and as such, agree that regardless of the insurance companies coverage, I am responsible for all fees incurred as a result of treatment received at Christiana Dental Spa. I hereby authorize payment directly to Christiana Dental Spa of my group dental benefits, otherwise payable to me. My payment (or co-payment, if there is dental insurance) is due at the time of service.

I hereby authorize Christiana Dental Spa to administer such medication and perform such diagnostic, photographic and therapeutic procedures as may be necessary for the proper dental care. The information on this "Authorization" page and the dental/medical histories that I have submitted are correct to the best of my knowledge.

I grant consent to the dentist to the use and disclosure of protected health information to carry out treatment, payment activities, and health care operations. I further grant release of my dental/medical history and information to third party payors and/or health professionals, whether manually or electronically. A copy of the "HIPAA Notices of Privacy Practices" has been provided to me.

PRINTED NAME _____

SIGNATURE OF PATIENT OR PARENT _____

DATE _____