

PRIMARY DENTAL INSURANCE:

Name of Insured Person: _____

Employer/Retired From: _____

Name of Insurance Company: _____

SECONDARY DENTAL INSURANCE:

Name of Insured Person: _____

Employer/Retired From: _____

Name of Insurance Company: _____

I hereby authorize the provider to file my insurance and benefits to be paid directly to the provider. I also understand that when my particular insurance is filed:

1. I authorize the release of any information related to my claim to my insurance company.
2. I am ultimately responsible for the balance on my account for any professional services rendered regardless of the amount my insurance pays toward my account. We ask that patients with insurance pay estimated portion of the cost of treatment; at the time service is received.
3. Any balance not paid by my insurance will be due within two weeks of the statement date, a **FINANCE CHARGE** may be added to the account. The **FINANCE CHARGE** will be a periodic rate **1.5%** per month, which is an **ANNUAL PERCENTAGE RATE of 18%**, applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

If patient is under the age of 18 years old, please complete the following:

Responsible Party: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

I ~ HAVE ~ DO NOT HAVE dental insurance. I am financially responsible for fees incurred at the time of service.

X _____ DATE
SIGNATURE OF PATIENT (CUSTODIAL PARENT/GUARDIAN OF MINOR)



Grand River
ENDODONTICS PC

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting a staff member of our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to any staff member of our office. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a representative on behalf of the patient signs this Consent form, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

INFORMED CONSENT

I, the undersigned, affirm all information provided is accurate. I understand that treatment is no guarantee of success, and that factors such as infection, pain, tooth fracture, and other complications (i.e. separation of an instrument within the root, root perforation) may affect the outcome of treatment. I understand that any fees incurred, even if covered with dental insurance, are the responsibility of the patient/guardian. Any questions will be answered and I have the right to deny treatment.

Any balance over 90 days is subject to a finance charge. I also understand that I am to return to my dentist for a permanent restoration of the treated tooth.

My signature signifies that I have read and understand the above information.

PATIENT _____
Signature Date

(If patient is a minor: Parent signature required)

