Dr. Paul R. Stanovick D.D.S.

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

- Consent for treatment
  I authorize Dr. Paul R. Stanovick to provide dental treatment to myself and or my dependent.

- Release of Dental Information
  I authorize Dr. Paul R. Stanovick to release necessary dental information to my insurance company, its agents, or any third-party payor in order for payable benefits for these services to be determined. In order to file insurance we have to have card holders social security number and birth date, since we file electronically, if you do not wish to disclose this information we do ask that you file your own insurance.

- Financial Responsibility
  I understand that Dr. Paul R. Stanovick will file my insurance claims as a courtesy; and accept assignment of benefits if I provide a current copy of my insurance card at each visit, however, I am ultimately responsible for full payment of all charges. My insurance is a contract between myself and my insurance company, Dr. Stanovick's office is not a party to that contract. I also understand that I am responsible for all co-payments and deductibles at the time of my appointment. I further understand my account will be charged a finance charge for balances over 30 days old. If my account is referred to a collection agency or attorney I will be responsible for all expenses and a 33.33% collection fee.

- Minor Patients
  The adult accompanying the minor and/or the parents (guardian of minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless previous arrangements have been made through our billing coordinator, by way of check, credit card (Visa or Mastercard), debit card, cash, or money order. INITIAL_____

- Confirming Appointments
  We call to confirm your appointments as a courtesy to you. It is important for you to update all phone numbers at each visit. We reserve the right to fill your appointment if you do not call us back to confirm the appointment.

- Missed Appointment
  We require at least 24 hours notice if you must cancel an appointment, failure to do so will result in a $44.00 "no show" fee.

- Returned Checks
  Our office will charge $30.00 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

_____ _____

Signature of Patient or Responsible Party Date

Please sign HIPPA form on the back of this page. Thank you

Dr. Paul R. Stanovick D.D.S.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. This notice is available in our office. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for Dr. Paul R. Stanovick. I understand the purpose of the authorized use of disclosure from another entity that is subject to the privacy rule of Dr. Paul R. Stanovick for treatment, payment or health care purposes. I also understand that if the organization authorized to receive my PHI is not a health plan or health care provider, that organization may disclose my PHI. In the event that this happens, I understand that my information may no longer be protected under the federal privacy rule and regulations. I understand that this authorization is voluntary. I understand that I may copy and/or inspect my PHI to be used or disclosed in accordance with Dr. Paul R. Stanovick's policy. I understand that I may ask questions of Dr. Paul R. Stanovick, if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____
(Printed Name of Patient) (Date)

_____ _____
(Signature of Patient/Patient's Representative) (Date)

_____ _____
(Printed Name of Patient's Representative) (Date)