ALPHA dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. AUTHRIZATION TO RELEASE INFORMATIONAND AUTHORIZATION OF PAYMENT OF BENEFITS.

I have received a copy of Alpha Dental's Notice of privacy practices effective February 7, 2007.

I hereby authorize Alpha Dental to provide any insurance company(s), claim administrator(s) and consulting healthcare professional(s), information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize payment directly to Alpha Dental. I agree that a photocopy of this authorization is as valid as the original.

Signature: _____ Date:_____
(If patient is a minor, Parent or Guardian must sign here and complete section below)

PAYMENT AGREEMENT:
I understand and agree that payment is due at the time services are rendered and that health and dental and accident insurance policies are an arrangement between and insurance carrier and I. I understand that this office will prepare any necessary dental reports and dental forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment regardless of insurance. In the event my account balance is referred to any agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein. I understand that if I suspend or terminate any care and treatment to me or to any person referred to in the previous sentence, any fees for professional services rendered will be immediately due and payable.

Signature:_____ Date:_____
(If patient is a minor, Parent or Guardian must sign here and complete section below)

RESPONSIBLE PARTY:_____
(Dr/Mr/Mrs/Ms/Miss) First Middle Last Jr/Sr

_____ M or F
SSN DOB Sex

_____
Street City State Zip

(____) (____) _____
Home Phone Work Phone Employer

METHOD OF PAYMENT: How will you pay for today's visit?
☐ **Cash** ☐ **Bank Check** ☐ **Capital One** ☐ **Charge Card*** ☐ **Other**_____
Unicorn

***See Receptionist for Application Forms**

CHARGE CARD AUTHORIZATION

By signing hereunder, I hereby authorize Alpha Dental to bill my charge card account should balance for services rendered remain outstanding for more than (60) sixty days. If the account information given expires or is otherwise discontinued, I agree to give Alpha Dental information as to an alternate charge account, which may be used. My account is as follows:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express Card #_____Exp Date_____

Signature_____ Date_____
Treatment Plan Release 02/07