DENTAL ARTS GROUP
1136 Hartford Avenue • Johnston, RI 02919

INSURANCE AUTHORIZATION

The above information is accurate and complete to the best of my knowledge. I hereby authorize insurance payment directly to dental office. I understand that I am responsible for all costs of dental treatment and I understand that my dental insurance carrier may pay less than the actual bill of services. I hereby authorize dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I understand that I am responsible for all fees incurred for the above treatment and agree to pay according to the option I have chosen. Most insurance plans are payment assistant plans. They are not design to cover the entire cost of treatment. This office is happy to assist you so that you can receive any entitled reimbursements. I also authorize the release of information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If insurance benefits received do not match the amounts estimated, I realize I am responsible for the remaining balance. **Any and all co-payments are due in full when services are rendered. Extended payment plans are available through Care Credit. Any account balance over 45 days will incur a 1.5% finance charge. Additional charges may occur if the account is turned over for collection. If matters turn over to collections, I agree to pay all court costs and attorney fees.**

PATIENT NAME (PRINT):

X _____ Date: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE:

X _____ Date _____

HIPAA AUTHORIZATION

I hereby authorize Dental Arts Group to release the following personal health information: Dental services claims information. Prescriptions, diagnostic, treatment, and/or care management services. Review required by HHS or HIPAA- compliant health care operations. Communication from the dental office by Telephone, Email, Fax, Postal Service or any means that the office feels efficient to contact me regarding the above mentioned statements.
A copy of the office practices have been received and reviewed.

PATIENT/RESPONSIBLE PARTY SIGNATURE:

X _____ Date _____

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