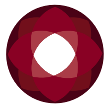

Santiago Dental Wellness

SEDATION. IMPLANTS. AESTHETICS.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

____

Signature Date

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

You may share the following health care information with:

Name:______________________________Relationship:__________________

Please check all that apply:

☐ All health care information on my dental record ☐ Insurance and billing information

☐ Other (appointments, test results, etc.)____________________________

This authorization ends:

☐ In 90 days from the date signed ☐ On (date):____________________

____

Signature Date

Assignment and Release: I authorize the dentist or employer benefit plan to release any information in accordance to HIPPA guidelines required for payment or review of this claim. I hereby authorize my insurance benefits to be paid directly to the dentist and I understand I am financially responsible for any balance due. I have reviewed the payment policy above.

____

Signature Date

____

Print Name