PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to dental care/diagnosis treatment and or dental surgical treatment by Eastlake Center for Implants and Restorative Dentistry deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examination in the office. I authorize the release of any of my past/current dental or medical records that are need for my treatment from any prior healthcare provider.

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Eastlake Center for Implants and Restorative Dentistry to furnish information to any insurance carrier(s) concerning my dental condition/illness and treatment, to determine the benefits related to services provided. I hereby authorize (assign) my insurance carrier(s) to make payment directly to Eastlake Center for Implants and Restorative Dentistry for dental/diagnostic/surgical benefits payable for the services rendered. I understand any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that my insurance carrier(s) do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this dentist’s office for services rendered. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify the office of any changes in my status or changes in the above information.

DESIGNATED RELATIVE

I authorize discussion and release of my general dental condition and diagnosis (including treatment, payment and healthcare operations) with relative(s) listed below. Please list family members or significant others, if any, whom we may inform about your dental condition, and /or in case of an emergency. I also specifically authorize the persons listed below to pick up prescriptions or radiology films for me if I am not able to do so. This authorization will remain in effect until revoked in writing.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Messages may be left on my answering machine regarding my dental appointments made Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

HIPAA PRIVACY NOTICE

I have received a copy of Eastlake Center for Implants and Restorative Dentistry’s Privacy Notice Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_

I certify I have read and understand all above information. I am authorizing treatment and authorizing my insurance to be billed for treatment. I also certify that the information I have given here is true and correct to the best of my knowledge. I will notify the office of any changes in my status or changes in the above information. I understand there is a 24-hour cancellation policy. I understand if I do not cancel my appointment within 24 hours or fail my appointment, there will be a $50.00 charge.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_