

Clackamas Smiles Family Dental

AUTHORIZATION & DISCLOSURE (HIPPA)

CREDIT POLICY & FEES DISCLOSURE  
ASSIGNMENT OF INSURANCE BENEFITS  
AUTHORIZATION TO RELEASE INFORMATION  
FINANCIAL RESPONSIBILITY

Truth-in lending disclosure: In accordance with the Federal Truth-in Lending act, we are providing the following information about our credit and fee policy:

- 1- Patient portion is due at the time of service. (unless other arrangements have been made with the front office)
- 2- Balances extended beyond 60 days from the date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%) AND MAY GO TO COLLECTIONS.
- 3- There will be a 50.00 fee charged for cancellations with less than 48 hours notice.
- 4- There will be a 50.00 fee for all returned checks.

Assignment of Insurance Benefits: I hereby authorize Dr Suess Family Dental to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Dr Suess.

Authorization to Release Information: I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluation and administering claims or insurance benefits.

Financial Responsibility: I understand that it is my responsibility to provide complete, accurate, and information on my insurance coverage (s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

Authorization to perform Procedures: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Authorization to Transfer Records: I authorize Dr Suess Family Dental to transfer records when necessary on my behalf.

I HAVE READ & FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COST OF DENTAL TREATMENT.

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Print full name (patient or responsible person, if patient is a minor)

\_\_\_\_\_ Date \_\_\_\_\_

Signature