Kirkwood Dental
ASSOCIATES, P.A.
WHERE SMILES NEVER END!

HIPAA, INSURANCE, RECORDS RELEASE, CONTACT CONSENT

I have received a copy of KIRKWOOD DENTAL Notice of Privacy Practices from the website

I authorize the release of any medical or dental information to my insurance company when necessary to process my claims. The authorization also permits the release of medical and dental information to Kirkwood Dental from the insurance company.

I authorize payment from the insurance company be made directly to Kirkwood Dental. If payment is made to me, I agree to pay that amount to Kirkwood Dental. I agree that if the amount paid by the insurance is insufficient to cover the bill, I will be responsible for payment of the difference and if my treatment is not covered by my insurance policy, I will be responsible for the entire amount.

If the need arises that an x-ray and/or dental records need to be sent to a specialist/referral, no fee will apply. If you request that your records be transferred, a release form will need to be signed.

In the event that the office is contacted by a family member, employer, or school office, I give the office of Kirkwood Dental permission to let them know that I am/was here.

Printed Name _____

Signature _____**Date:** _____