Key Family Dental Center, PLLC

Authorizations, Acknowledgements and Agreements

_______ I have had the opportunity to review the **HIPAA Notice of Privacy Practices** and the full HIPAA Authorization (document HIPAA03202013) (A copy is posted in the office and I acknowledge that I have a right to receive a copy). I understand and acknowledge the terms of my authorization to use my protected health information.

_______ I have had an opportunity to review the **Financial Policy** (document FA03202013). I understand and agree to the terms as outlined.

_______ I have had the opportunity to review the **Appointments and Cancellation Policy** (document A&C03202013). I understand and agree to the terms as outlined.

_______ I authorize Key Family Dental Center, PLLC to submit claims and exchange information about my dental care, and the dental care provided to all dependents covered by my insurance plan, with third party billing agents and insurance companies.

_______ I authorize payments from third party billing agents and insurance companies for all dental care received by me or dependents covered by my insurance plan, to be paid directly to Key Family Dental Center, PLLC.

_______ I authorize Key Family Dental Center, PLLC to collaborate with and exchange all information related to my dental care, as well as care provided to dependents covered under my insurance, with other healthcare providers.

_______ I authorize staff of Key Family Dental Center, PLLC to take photographs, slides and of videos of my face, jaws and teeth as a record of my dental care. If I have Dental Insurance, I allow this information to be used to support

_______ I understand that In the event that I do not wish to proceed with recommended treatment, I may refuse and sign an informed refusal.

_______ I understand that no guarantees can be made for the outcome of dental treatment I receive.

_______ I understand that any verbal or written quote given for my portion of my dental bill is an estimate of my financial responsibility and that I am responsible for any remaining balance after insurance pays or denies services.

_______ I agree to receive email and voice messages regarding my treatment, appointment reminders and appointment confirmations.

Patient Name: ______________________________ Date: ____________________

Signature: ______________________________
Signature

Other Family Members Covered by this Authorization:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

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