DENTAL HEALTH
ASSOCIATES

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr.Calvano/ La Grua for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether or not paid by insurance and any co-payments/deductibles and other fees are due at time of service. I authorize the above doctor(s) and /or any provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and healthcare operations. I authorize the use of this signature on all insurance submissions. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you and or to continue treating you if you revoke this Consent. In the event that my account must be turned over for outside collection, I agree to pay all costs related to collection, to include any court costs and attorney fees that may accrue, and an office collection fee of $35.00. I understand that any account information necessary for collection will be released to a collection company that may affect my credit report.

_____

Patient Signature-I have read the above and authorize assignment of Insurance Benefits

Acknowledgement of Receipt of Notice of Privacy Practices

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I_____, have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name (and child's name, if he or she is the patient)

_____

Your signature

_____

Date

Consent for Personal Health Information

By signing below, I request that the following have access to my Personal Health Information. (PHI) or phone numbers:

_____ _____

Print Patient Name Date of Birth

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Patient Signature Date

I Hereby VOID the above request. _____

Patient Name/Date

This acknowledgement page will be retained in the patient record.