ASSIGNMENT OF BENEFITS

I hereby authorize payment of dental benefits to the provider for services rendered. I fully understand I am solely responsible for the balance not paid by my insurance company.

Patient Name (print)_____ Date_____

Signature of patient or Authorized Rep_____

RELEASE OF MEDICAL INFORMATION

Please ***INITIAL*** the appropriate boxes:

( ) I authorize the release of pertinent medical information relating to my treatment (including diagnosis, records, and billing) to:

- ( ) SPOUSE_____
- ( ) CHILD/CHILDREN_____
- ( ) OTHER_____

( ) I authorize the release of dental records and other information to my family physician, the doctor to whom I am referred, my legal counsel, and to applicable third-party payer.

( ) Information is ***NOT*** to be released to anyone

( ) I authorize Dr. Frank Novak and office staff to email or fax pictures, x-rays, appointment reminders, school and work excuses, statements and receipts.

CONTACT INFORMATION

Please contact me at the following telephone number (s): HOME_____

WORK_____ CELL_____

Please ***INITIAL*** the appropriate boxes: ( ) Leave a detailed voice message

( ) Send a detailed text message

( ) Leave message asking for return call

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, the use and disclosures we may make and other important matters about your protected health information. If we change our privacy practices, we will issue a revised Notice of Privacy Practices.

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release. I acknowledge receipt of Dr. Novak's Privacy Practices.

Today's Date_____

Name (print)_____ Date of Birth_____

Signature (patient or authorized rep)_____