*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 (please print) **Signature of patient or Authorized Rep.** **Date**

*RELEASE OF INFORMATION

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 the applicable third-party payer.

_____ _____

Signature of Patient or Authorized Rep. **Date**

*HIPPA RELEASE OF INFORMATION

To insure the proper handling & disclosure of your information, please complete the following:

HOME#_____CELL#_____
WORK#_____E-MAIL_____

I authorize the release of pertinent medical information relating to my treatment to:
Please initial your choice (s).

_____May release medical information to my spouse: Name_____
_____May release medical information to my parent (s): Name_____
_____May release medical information to the designated person (s):
Name: _____
Name: _____

*CONTACT INFORMATION:

Please initial your choice (s).

_____May leave a message on the answering machine at home/work/cell to confirm a dental appointment or to contact the office.
_____May contact via e-mail.
_____May contact by texting.

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, and healthcare operations, of the use and disclosures we may make of your protected health information, and of 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.

Signature of Patient or Authorized Representative_____ **Date**_____