PEDIATRIC DENTISTRY OF NORTHBROOK & HIGHLAND PARK

RELEASE OF INFORMATION

Full Name of Patient(s)_____

***Please **INITIAL** each section marked with an asterisk to accept the terms outlined

***_____ Privacy Notice:**

I hereby acknowledge that I received the Notice of Privacy Practices from Pediatric Dentistry of Northbrook, Ltd.

***_____ Authorization to Discuss Medical/Dental Care and Account Information:**

It is the policy of this practice to call our patients to confirm and to reschedule appointments, or leave information with results. When we call, we may leave a message on your home or cellular voicemail or speak with whoever answers the phone.

If you are the patient 18 or over, please indicate a person(s) other than yourself we can speak to about your care.

_____

Person(s) authorized to receive information Relationship(s) to patient

***_____ Consent for Treatment:**

I hereby consent to treatment provided by Pediatric Dentistry of Northbrook, Ltd, the dentists, employees, or designees and authorize dental services, diagnostic procedures and medications as deemed necessary or advisable.

***_____ Release of Information and Assignment of Benefits:**

I understand that I am responsible for any fees for services rendered for myself and/or my children. I hereby authorize Pediatric Dentistry of Northbrook, Ltd to furnish information to my insurance carrier concerning all conditions. I hereby assign to Pediatric Dentistry of Northbrook, Ltd payments made by my insurance carrier. I authorize Pediatric Dentistry of Northbrook, Ltd to obtain any pertinent information needed for my care.

***_____ Patient Financial Responsibility**:

I understand that Pediatric Dentistry of Northbrook, Ltd will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. If there is any question regarding coverage, benefits, or payment for services provided, I understand that it is my responsibility to resolve the issue(s). I also understand that I am financially responsible for any covered or non-covered services that are not paid by my primary or secondary insurance. Any unpaid charges over 60 days old will become my responsibility with payment due from me plus a processing amount of $20.00 added monthly. In the event that my account is placed with an agency for collection purposes, I understand that I am responsible for all collection agency fees (30% of the balance placed in collection). In addition, I am responsible for all court costs, filing fees, and attorney fees (an additional 10% of the balance), should this account require litigation.

My signature below indicates my knowledge of and agreement with all of the above.

_____

Signature of parent, guardian, or patient 18 years and over Printed name

_____

Relation to patient Date

OFFICE USE ONLY

In lieu of the parent, guardian, or patient signature, I_____, a staff member of Pediatric Dentistry of Northbrook, Ltd, state this patient was offered our current Notice of Privacy Practices.