

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 contact our patients to confirm or reschedule appointments, or leave information with results. We may text, email, leave a message on your home/cell 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. In addition, I am responsible for all court costs, filing fees, and attorney fees, 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.