Patient Name: _____ Date: _____

Financial Agreement & Release of Information

Authorization for Treatment

I hereby authorize treatment by RL Howell DDS & Associates, A Division of Atlantic Dental Care, PLC (RLHDDS) on behalf of myself and/ or my minor child, including stepchildren. I understand that during treatment, the possibility exists for health care workers to become directly exposed to my blood or body fluids (or my child's). In the event of such direct exposure in a manner which may, according to Center for Disease Control Guidelines, transmit AIDS a sample of my blood will be tested for the presence of infectious diseases such as hepatitis, syphilis, and HIV. I consent that the results of the test will be released to me and the health care worker who was exposed. I further understand that I will be given an explanation about procedures and will be given the opportunity to ask questions.

Initials _____

Release of Information

I hereby authorize the release of any and all medical and/or charge information as is necessary for third party reimbursement from any governmental agency or insurance payer involved in the payment of my treatment (or) my child's treatment. I authorize the release of any and all medical information to any physician and/or hospital involved in my care (or) my child's care. In addition, I authorize the use of information from my medical record (or) my child's medical record for the purpose of clinic quality improvement if such information is provided as required by applicable law in manner that sufficiently protects my private health information. I also authorize the take and use of photographs. I understand that these photos will become part of my medical record (or) my child's medical record. I hereby authorize representatives of RLHDDS to leave appointment reminders on my answering machine. I acknowledge that RLHDDS retains all medical records for at least 10 years.

Initials _____

Obligation of Payment

For those without dental insurance: I understand that all payment is due at time of service and that I assume all charges for treatment rendered. Upon default on any payment due, I agree to pay all interest fees or collection costs incurred.

For those with dental insurance: I will direct and assign payment from my insurance company to RLHDDS. I understand that my insurance policy is a contract between me and my insurance company, and that I am responsible to RLHDDS for any charges not covered by my insurance including co-payments, deductibles, and fees for non-covered services. Upon default on any payment due to RLHDDS, I agree to pay all interest fees or collection costs incurred.

Initials _____

Balances Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. I understand that co-payments and deductibles are due at time of appointment. We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $30.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. I have been informed that a $35.00 fee will be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash, money order, or by credit card. Please ask to speak with a billing representative if you have any questions regarding these issues.

Initials _____

Employee Signature: _____ Date: _____