

# Downtown Dental Care

511 SW 10th Ave, Suite 1114

Portland, OR 97205

(503) 228-4122

## **AUTHORIZATION & DISCLOSURE (HIPAA)**

### CREDIT POLICY & FEES DISCLOSURE ASSIGNMENT OF INSURANCE BENEFITS AUTHORIZATION TO RELEASE INFORMATION FINANCIAL RESPONSIBILITY

**Truth-in lending disclosure:** In accordance with the Federal Truth-In Lending act, we are providing the following information about our credit and fee policy:

1. Patient portion is due at the time of service.
2. Balances extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%)
3. **There will be a \$50.00 fee charged per hour for cancellations with less than 48-hour notice.**
4. There will be a \$25.00 fee charged for all returned checks.

**Assignment of Insurance Benefits:** I hereby authorize Downtown Dental Care to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Downtown Dental Care.

**Authorization to Release Information:** I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

**Financial Responsibility:** I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

**Authorization to Perform Procedures:** I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

**Authorization to Transfer Records:** I authorize Downtown Dental Care to transfer records when necessary on my behalf.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES OF THIS DENTAL OFFICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

\_\_\_\_\_  
Print full name  
(Patient or Responsible Person, if patient is a minor)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

I authorize Downtown Dental Care to place my picture on the No Cavity Club board. **YES** **NO**  
(please circle one)

Authorization valid until specifically revoked in writing