BRIAN P. KRANDELL DDS PA

Authorization for Release of Information

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical and/ or dental information for this or any related claim, to my insurance carrier. Either my insurance carrier or I may revoke this authorization at any time in writing.

INITIAL _____

Assignment of Benefits

I hereby authorize payment of all medical/dental benefits which are payable to me under the terms of my insurance policy to be paid directly to the above named physician for services rendered. *

INITIAL _____

**A copy of the above authorizations may be used in place of the original.*

Notice of Privacy Acknowledgement

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time. A full description is available upon request.

INITIAL _____

Financial Agreement

I hereby assume financial responsibility for and agree to make payment in full to Brian P. Krandell DDS PA for all charges for services furnished to me or my dependents, whether this be my deductible, coinsurance, copay, otherwise allowable amount determined by my insurance company. This also includes services not authorized or paid for by my insurance carrier. **ANY BALANCE DUE IS TO BE PAID IN FULL UPON RECEIPT OF STATEMENTS. I UNDERSTAND THAT ALL COPAYMENTS, COINSURANCE, AND DEDUCTIBLE AMOUNTS, AS DETERMINED BY MY INSURANCE CARRIER, ARE TO BE PAID AT THE TIME OF SERVICE.** In the event my account becomes delinquent and is referred to a collection agency or attorney, I shall be responsible for the reasonable costs of collections, also to include court costs. I certify that the financial information given is true, accurate, and complete to the best of my knowledge.

INITIAL _____

A fee of $35 will be charged for any check not honored by your bank. There is a $50 charge for any missed appointment. Any appointment must be cancelled at least 24 hours in advance.

INITIAL _____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES TO MY ADDRESS, PHONE NUMBER, AND INSURANCE.

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Printed Name of Patient

_____

Signature of Patient or Responsible Party Date