Dr. James Willis Dr. Emery Taylor Dr. Brian Podbesek
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www.crozetfamilydental@gmail.com

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Crozet Family Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether or not paid by insurance. I authorize the above doctor(s) and /or any provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and healthcare operations. I authorize the use of this signature (at the end of this form) on all insurance submissions.

FINANCIAL POLICY

Payment of fees and co-payments/deductibles are expected at the time of service. In the event that my account must be turned over for outside collection, I agree to pay all costs related to collection, to include any court costs and attorney fees that may accrue, and an office collection fee of $ 35.00. I understand that any account information necessary for collection will be released to a collection company that may affect my credit report. I also understand that I may be billed a $35.00 returned check fee for any check returned for insufficient funds.

OFFICE POLICY

Appointments: a minimum charge may be made for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment may result in a missed appointment fee of $ 50.00 and, should this happen three times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. PLEASE REMEMBER THAT ONCE AN APPOINTMENT IS MADE, THIS TIME IS RESERVED ESPECIALLY FOR YOU

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you and or to continue treating you if you revoke this Consent

I, THE UNDERSIGNED, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE. I CERTIFY THAT THE INFORMATION ON THIS FORM IS ACCURATE, TO THE BEST OF MY KNOWLEDGE.

_____Date_____

Signature (Guardian if under 18 years of age)