CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient/Responsible Party: _____Signature_____Date____/____/____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate any claim for benefit.

Patient/Responsible Party: _____Signature_____Date____/____/____

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of Mountain Stream Dental to submit claims for payment for services to my health care service plans or insurance companies on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services***. I understand that I am financially responsible for any charges not covered by the insurance company.***

I understand the Mountain Stream Dental will make every effort possible to assist me with my insurance coverage. Mountain Stream Dental allows no more than 90 days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, Mountain Stream Dental will reimburse me or credit my account. It is my responsibility to pay any deductible, co-payment, or other balance not paid by my insurance company. Mountain Stream Dental requires my estimated portion at the time of service.

Patient/Responsible Party: _____Signature_____Date____/____/____

CANCELLATION

I understand that should I need to cancel an appointment time reserved specifically for me, I will notify the dental office at least 72 hours in advance so that my time may be utilized by another patient.

Patient/Responsible Party: _____Signature_____Date____/____/____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way

Patient/Responsible Party: _____Signature_____Date____/____/____

MOUNTAIN STREAM
DENTAL