Authorization and Release WAHOO DENTAL ASSOCIATES

I certify that the information provided on the Patient Registration form is true and correct to the best of my knowledge and belief. I authorize the physician to release any information including the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and /or health practitioners. I am aware that Medicare does not provide coverage for dental services and this office is not a Medicare provider.

Payment Policy

I authorize and request my insurance company to pay directly to the physician's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. **I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances.** Any balance that remains past due for 60 days or more is subject to an interest charge. APR is 16%; Minimum interest charge is $1.00.

Communication agreement

A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number or place a cellular phone call to physician or any of our service providers, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

Patient Name:_____

Signature of Patient/Guarantor

x_____Date_____

We will be providing reminders to our patients regarding upcoming appointments via Email and Text messaging.
Please provide the following:
Email:_____

Cell Phone number:_____

- o I agree to accept email messages from Wahoo Dental Associates
- o I agree to accept text messages from Wahoo Dental Associates