AUTHORIZATION FOR SIGNATURE ON FILE

I hereby authorized the office of LC Quality Dental to affix my name to any and all claims or documents as related to any and all health benefits documents and my dependent. I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.
This “authorization” will be valid from this date and shall expire in ten year. A photocopy of this document may act as an original.

Signature of Patient (parent/guardian if a minor): _______________ Date: _______

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding to my protected health information I understand that this information can and will be used to:

- ✧ Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✧ Obtain payment from third party payers
- ✧ Conduct normal healthcare operations such quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more 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 and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient (parent/guardian if a minor): _______________ Date: _______