



Assignment Of Benefits Form

I hereby assign all dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s) directly to Dr. Todd Resek and Dr. Sean Bell for dental services rendered to myself and/or my dependents regardless of my insurance benefits.

I understand that I am responsible for any amount not covered by insurance. I also understand that all estimates given are only an estimate and total owed may be more/less after insurance pays.

Authorization Release Information

I hereby authorize Oakmont Advanced Dentistry to: 1. Release any information necessary to insurance carriers regarding my treatment. 2. Process insurance claims generated in the course of examination or treatment. 3. Allow my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested dental services from Oakmont Advanced Dentistry on behalf of myself and/or my dependents and understand that by making this request, I become fully responsible for any/all charges incurred in the course of treatment.

I further understand that fees are due on the date that services are rendered and agree to pay all such charges incurred that my insurance does not cover, upon receipt of an appropriate statement.

Notice of Privacy Practice Acknowledgement (HIPAA)

I understand that, under the Health Insurance Portability & Accountability act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment among the multiple healthcare providers who may be involved in that treatment directly or indirectly. 2. Obtain payments from third party payers. 3. Conduct normal healthcare operations, such as assessments and certifications.

By signing this document, I also acknowledge that I can request 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 and that I may contact this organization at any time to obtain a current copy. 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Special Considerations for SUD Record Management: If we receive SUD (substance use disorder) records as the result of a disclosure authorized by you, we are permitted to use and disclose those records for treatment, payment, and/or operations (TPO) purposes in accordance with HIPAA regulations unless you revoke the authorization in writing. We may disclose those records to public health authorities without your consent, but only if those records have been fully de-identified according to HIPAA regulations. We will not release those records or your testimony regarding those records for matters of criminal, administrative, legislative, or civil proceedings against you by a local, state, or federal authority unless we receive a court order or a separate and specific patient consent from you. You may request an accounting of all TPO disclosures of SUD records made electronically for up to three years prior to the date of the request. We will not use or disclose your SUD records to fundraise for our own benefit.

Patient/Guardian Signature: _____

Date: _____