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DO YOU HAVE DENTAL INSURANCE THAT MAY COVER PART OR ALL OF TODAY'S TREATMENT? IF SO, YOU NEED TO FILL OUT THIS INFORMATION:

ABOUT THE POLICY HOLDER:

The Policy Holder (the Insured) ____

The Policy Holder's *Social Security Number* ______________________________

The Policy Holder's *Date of Birth* ________/________/____________

ABOUT THE PATIENT:

If it is the same as above, stop here and sign.

If it is different, then we need your *Date of Birth* ________/________/____________

Please sign below. This is "*Release of Information*" and "*Assignment of Benefits*."
ASSIGNMENT means the insurance company sends the insurance check here.
If you prefer to pay us directly and receive your check at your home, please let us know.

AUTHORIZATION

I HAVE BEEN INFORMED OF THE TREATMENT PLAN AND ASSOCIATED FEES. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES PROVIDED BY APEX DENTAL NOT PAID FOR BY MY INSURANCE PLAN, UNLESS PROHIBITED BY LAW OR IF THE PARTICIPATING DENTIST HAS A CONTRACTUAL AGREEMENT WITH THE PARTICIPATING PLAN. TO THE EXTENT PERMITTED BY LAW, I CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT PAYMENT ACTIVITIES IN CONNECTION WITH THIS CLAIM.

____
PATIENT/GUARDIAN

________/________/____________
DATE

I HEREBY AUTHORIZE AND DIRECT PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME, DIRECTLY TO THE ABOVE NAMED DENTIST OR ENTITY.

____
SUBSCRIBER'S NAME