PIKE LAKE DENTAL AUTHORIZATION & RELEASE FORM

PRIMARY INSURANCE INFORMATION:

THIS SECTION IS FOR INFORMATION REFERRING TO THE INSURED ONLY.

NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOCIAL SECURITY NUMBER _____

CITY _____ STATE _____ ZIP _____ TELEPHONE NUMBER _____

EMPLOYER _____ TELEPHONE NUMBER _____

EMPLOYER ADDRESS _____

INSURANCE COMPANY _____ TELEPHONE NUMBER _____

INSURANCE ADDRESS _____

GROUP NAME/ NUMBER _____

SECONDARY INSURANCE INFORMATION: PLEASE ANSWER WITH THE INSURED'S INFORMATION.

NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOCIAL SECURITY NUMBER _____

CITY _____ STATE _____ ZIP _____ TELEPHONE NUMBER _____

EMPLOYER _____ TELEPHONE NUMBER _____

EMPLOYER ADDRESS _____

INSURANCE COMPANY _____ TELEPHONE NUMBER _____

INSURANCE ADDRESS _____

GROUP NAME/ NUMBER _____

DEPENDENT(S)

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

Please bring these insurance cards to your upcoming appointment.

PIKE LAKE
DENTAL CENTER

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AUTHORIZATION & RELEASE FORM

* Please read and initial on the lines provided. Please sign and date on the bottom line provided.

_____ I authorize Dr. Matthew Jugovich to release any information to the third party payers and/or other health care practitioners, including: diagnosis and the records of any treatments or examination rendered to me or my child during the period of such dental care.

_____ I authorize and request my insurance company to pay directly to Dr. Matthew Jugovich, the insurance benefits otherwise payable to me.

_____ If my insurance company pays directly to me, I agree to sign the check over to Dr. Matthew Jugovich, or send payment in full within 10 days of receiving the check.

_____ I understand that my dental insurance carrier is likely to pay less than the actual charges for services, and may require me to submit a co-pay for treatment.

_____ I agree to pay the amount charged by Dr. Matthew Jugovich in a timely manner for all professional treatment and services provided to me or my family.

_____ If an unpaid balance remains sixty days after the treatment date, I agree to pay the doctor a finance charge computed at the monthly periodic rate allowed by law in Minnesota: 1.5% per month, or 18% per year.

_____ I can avoid incurring a finance charge by paying my account balance in full upon receipt of statement, provided that payment is actually received by the doctor before the next billing date. This allows for a minimum of thirty days from the date of service to pay my account without incurring a finance charge.

_____ If uninsured, I agree to pay in full at the time of treatment unless other payment arrangements have been made with the financial coordinator.

_____ I am aware that if I pay in full by cash, check, money order or credit card on the date of service, I am entitled to a 5% discount on that day's charges. This discount does not apply to post-dated checks.

_____ I am aware that, prior to engaging in a large treatment plan, I will meet with the financial coordinator and discuss my method of payment for this dental treatment.

_____ I agree to provide at least 24 hours notice if unable to keep a scheduled appointment.

_____ I am aware that I may be charged a broken appointment fee of $75.00 per appointment for broken appointments without a 24 hour advance notice. This fee must be paid in full prior to rescheduling the appointment.

_____

Signature of patient or parent/guardian (if patient is a minor) Date

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